MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10394

.10431

Reg. Dist. No. 2 8

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Burnham Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: Burnham Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: Yvonne — Last: Addison

4. DATE OF DEATH: Month: 10/19/56 — Day — Year: 19

5. SEX: female — 6. COLOR OR RACE: col. — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/29/56

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months: 2 — Days: 20 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Dosey Addison

14. MOTHER'S MAIDEN NAME: Doris Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Dorsey Addison(father) Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Found

475X

DUE TO (b): vomitus — dead in bed

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Upper Respiratory Infection — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 10/20/56

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: Oct 20/56 — 22c. NAME OF CEMETERY OR CREMATORY: Brookeville MH — 22d. LOCATION (City, town, or county) (State): Montgomery Co Md

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Brookeville Md — 24a. REC'D BY REGISTRAR DATE: Oct 23-56 — 24b. REGISTRAR'S SIGNATURE: Ursula L Cook

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA43. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5) SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10432

CERTIFICATE OF DEATH

Reg. Dist. No. 10395 2-16

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 16: 1 hour
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 74 Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase 15
d. STREET ADDRESS: 7729 Brookville Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jerry — Middle: William — Last: Bachman
4. DATE OF DEATH: Month: Oct — Day: 22 — Year: 1956
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/21/01
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SELF EMPLOYED
10b. KIND OF BUSINESS OR INDUSTRY: Paint Store
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: FREDRICK Bachman
14. MOTHER'S MAIDEN NAME: NEEDHAM, GRACE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 577-05-2737
17. INFORMANT: Wife - Item #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 45-60'
420.1
DUE TO (b): Acute Coronary Occlusion — 1½ hr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.): —
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State): Bethesda Montgomery Md

21. I certify that I attended the deceased from MAR 31, 1956 to Oct 22, 1956, that I last saw the deceased alive on Oct 22, 1956, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. J. Brennan M.D. — ADDRESS (Street, city or town, state): 4630 Montgomery Ave Bethesda Md — DATE SIGNED: —

PHYSICIAN'S NAME (Type): A. J. BRENNAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-25-56
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md
24a. REC'D BY REGISTRAR DATE: 10-24-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompkins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Brosnahan Released body 5 Autopsy

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10433 — 10396 — Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 611 Burgandy Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Charlie Middle: Louis Last: Baldwin
4. DATE OF DEATH Month Day: 10-6- Year: 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-28-05
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): sheet metal Worker
10b. KIND OF BUSINESS OR INDUSTRY: Navy Yard
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Tom S. Baldwin
14. MOTHER'S MAIDEN NAME: Nannie B. Toney
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Jesse Baldwin son Address: 5451 Burnside Circle Sandston, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Confluent Bronchopneumonia, bilateral	7-5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Gunshot wound, head	35 days
DUE TO (c)		

996 K

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Gunshot wound head, self inflicted
20c. TIME OF INJURY Hour: 9 p. m. Month, Day, Year: 9-5 1956
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank J. Broschart, M. D.
DATE SIGNED: 7 October 56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/11/56
22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl.
22d. LOCATION (City, town, or county) (State): Arlington Va
23. FUNERAL DIRECTOR'S SIGNATURE: W W Chambers Co ADDRESS: 517 11th St S. E.
24a. REC'D BY REGISTRAR: 11-9-56
24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

10397

MARYLAND — STATE DEPARTMETT OF HEALTH

10434 CERTIFICATE OF DEATH

Reg. Dist. No. 216

Items 8,9 FilmG205 10-11-56 et 1015

1. PLACE OF DEATH: COUNTY Montgomery — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase — LENGTH OF STAY (In this place) 7 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS 5324 Saratoga Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New York State — COUNTY Manhattan
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New York City
STREET ADDRESS (If rural, give location) 201 West 107 St NYC

3. NAME OF DECEASED (Type or Print): (First) Della (Middle) (Last) Barbour
4. DATE OF DEATH: (Month) Oct (Day) 3 (Year) 1956

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug 10 1864
9. AGE last birthday: 92 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress Designer
10b. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Whitney Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Carroll Yates
14. MOTHER'S MAIDEN NAME: Mary Jane Lawrence

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY No.: None
17. INFORMANT AND ADDRESS: Lillian Olivia Bearden 5324 Saratoga Ave Chevy Chase Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X **Immediate cause** (a) Cerebral Vascular Accident — 48 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 20, 1950 to Oct 3, 1956, that I last saw the deceased alive on Oct 3 1956, and that death occurred at 1 45 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Charles Reading MD — ADDRESS 4928 St Elmo Ave Beth Md. — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 10-5-56 — NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery — LOCATION (City, town, or county) (State): Rockville, Maryland

DATE REC'D BY LOCAL REG. 10-3-56 — REGISTRAR'S SIGNATURE: Bessie M. Thompson — 24. FUNERAL DIRECTOR — ADDRESS: George Chase Funeral Home 5301 Wis. Ave. DC

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10435

10398

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: Rt #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle Cleveland Last BENSON

4. DATE OF DEATH: Month October Day 2 Year 1956

5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/7/86
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months 1 Days 25
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: FIRE MAN
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Benson
14. MOTHER'S MAIDEN NAME: Henrietta GRIMES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-26-3740
17. INFORMANT: W. Benson — Son — Address: Same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardio-respir. failure	1 hr
DUE TO		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Myocardial Infarction	1 yr
DUE TO (c)	Coronary atherosclerosis	Indef
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).	Renal failure	

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 1956 to 10/2, 1956, that I last saw the deceased alive on 10/2/56, and that death occurred at 5:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen N. Jones M.D. ADDRESS (Street, city or town, state): Rockville, Md. DATE SIGNED: 10/2/56

PHYSICIAN'S NAME (Type): Stephen N. Jones Rockville, Md. 10/2/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-5-56
22c. NAME OF CEMETERY OR CREMATORY: Potomac Meth.Ch.Cem
22d. LOCATION (City, town, or county) (State): Potomac Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda Md
24a. REC'D BY REGISTRAR DATE: 10-6-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10436 10399

Reg. Dist No. 214

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c LENGTH OF STAY IN 1b 5 yrs
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10614 Dunster Rd

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md b. COUNTY Montg
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 10614 Dunster Rd
e RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Walter Middle Lee Last Berry
4. DATE OF DEATH Month Oct Day 13 Year 1956
5 SEX Male
6 COLOR OR RACE White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-1-1910
9 AGE (In years last birthday) 46 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman
10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't Ltr Co.
11 BIRTHPLACE (State or foreign country) Cal
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Reginald Berry
14. MOTHER'S MAIDEN NAME Edith Jenkins

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16 SOCIAL SECURITY NO 577-07-4961
17 INFORMANT Harriet Berry (wife) Same as #2 Address

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrown from motorcycle
DUE TO (b) Struck gas main, fractured left upper chest
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) motorcycle struck gas main
20c TIME OF INJURY Hour 2 p m Month Oct Day 13 Year 1956
20d INJURY OCCURRED While at work ☐ Not while at work ☒
20e PLACE OF INJURY (Home, Farm, factory street, off ce bldg., etc.) Street
20f (City or town) Silver Spring (County) Mont (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Bryant M.D
EXAMINER'S NAME (Type): FRANK J BRYANT
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 10-13-56

22a BURIAL CREMATION REMOVAL (Specify) BURIAL
22b DATE THEREOF 10/16/56
22c NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY
22d LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE Maurice L. Pumphrey, ADDRESS SILVER SPRING, MD.
24a REC'D BY REGISTRAR DATE 10/19/56
24b. REGISTRAR'S SIGNATURE Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word pending in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal

VS. ATSME(S) 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10437 — Reg. Dist. No. 10490 — 14

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring R.F.D.
c. LENGTH OF STAY IN 1b: 23yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Forest Glen

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont'g
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring - R-1
d. STREET ADDRESS: Forest Glen
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Winnifred — Last: Bostetter

4 DATE OF DEATH: Month: Oct — Day: 13 — Year: 19 58

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 6 - 81
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: N.F.H.
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Bostetter
14. MOTHER'S MAIDEN NAME: Mattie Powers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Thomas Bostetter (wife) Address: Route # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion	minutes
177X DUE TO (b)	Arteriosclerosis & hypertension	8 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl J Bischoff M.D
EXAMINER'S NAME (Type): EARL J BISCHOFF
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-15-58

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT 16, 1958
22c. NAME OF CEMETERY OR CREMATORY: GEORGE WASH'N CEM
22d. LOCATION (City, town or county): RIGGS RD — PRGEO CO (State) MD

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur Mellon ADDRESS: Takoma Park, Md. 254 Carroll St. N.W.
24a. REC'D BY REGISTRAR — DATE
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10438

CERTIFICATE OF DEATH

10491

Reg. Dist. No. 216

1 PLACE OF DEATH: a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b 2 Y2 YEARS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 202 OXFORD ST. CHEVY CHASE MD.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY CUMBERLAND
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARLISLE
d. STREET ADDRESS 256 SOUTH WEST ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LUCY Middle KATHLEEN Last BILLMAN
4. DATE OF DEATH: Month OCTOBER Day 2 Year 1956
5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: NOV. 7, 1877
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months 10 Days 25 IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: SAMUEL RICE
14. MOTHER'S MAIDEN NAME: MATILDA HALL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS. R. T. LEWIS Address 202 OXFORD ST. CHEVY CHASE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 10 HOURS
DUE TO (b) HYPERTENSION — OVER 8 YEARS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL 1956, to OCTOBER 1, 1956 that I last saw the deceased alive on OCTOBER 1 1956, and that death occurred at 3 45 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Joseph D. Connor, M.D. ADDRESS (Street, city or town, state) 9600 OLD GEORGETOWN ROAD DATE SIGNED
PHYSICIAN'S NAME (Type) JOSEPH D. CONNOR M.D. Bethesda 14, Md. Oct 2, 1956

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Tr.
22b. DATE THEREOF: 10-5-56
22c. NAME OF CEMETERY OR CREMATORY: Mt. Zion
22d. LOCATION (City, town or county) (State): Perry Co. Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda Md
24a. REC'D BY REGISTRAR DATE 10-2-56
24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10439

CERTIFICATE OF DEATH

10402

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Res dence before admission)
a STATE: Maryland — b COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and g ve nearest town): Bethesda 14, Md.

c. LENGTH OF STAY IN 1b: 115 days

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 208 Washington Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: Ann — Last: Blakslee

4 DATE OF DEATH: Month: October — Day: 29, — Year: 1956

5 SEX: Female

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ W DOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: December 25, 1931

9 AGE (In years last birthday): 24 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b. KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walter D. Hadley

14 MOTHER'S MAIDEN NAME: Agnes Newnan

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 222-20-8920

17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Lung Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO (b): Lymphocytosis — 1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Acute Lymphogenous Leukemia — ?

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pericarditis — 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 6, 19 56 to October 29, 19 56 that I last saw the deceased alive on October 29, 19 56, and that death occurred at ____ M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): Arthur J. Garceau, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Nov. 2, 1956 — 22c. NAME OF CEMETERY OR CREMATORY: Galena Cem. — 22d LOCATION (City, town, or county) (State): Galena, Kent Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Millington, Md. — 24a REC'D BY REGISTRAR DATE: NOV 5 — 24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10404

CERTIFICATE OF DEATH

10403

Reg. Dist. No. 223

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.)
a. STATE: Md. — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b: 3½ days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Emmitsburg

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San + Hosp

e. STREET ADDRESS: RT #1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Vennie — Middle: — Last: BLANKS

4. DATE OF DEATH: Month: 10 — Day: 12 — Year: 1956

5. SEX: F

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 10-27-1876

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Tenn

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nathaniel Pearson

14. MOTHER'S MAIDEN NAME: Matilda Jolly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hosp Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Emaciation — INTERVAL BETWEEN ONSET AND DEATH: months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Bed Terminal Bronchopneumonia — few hours

DUE TO (c): Chronic Bronchiectasis — 6 yrs. +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a.m. / p.m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/8/56, 19 56 to 10/11/56, 19 56 that I last saw the deceased alive on 10/11/56, 19 56, and that death occurred at 7:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. H. Wolohon, M.D. — ADDRESS (Street, city or town, state): 500 Underwood St. NW — DATE SIGNED: 10/12/56

PHYSICIAN'S NAME (Type): Chas H Wolohon — Washington D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10/15/56 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill — 22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: 300 4th St NE

24a. REC'D BY REGISTRAR DATE: 10/17/56 — 24b. REGISTRAR'S SIGNATURE: J. Hutchisson

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be forwarded with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10440

10404

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL- Norbeck, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: St. Philomena's Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Dist. Of Col. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 1604 - Buchanan Street N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK — Middle — Last BORZI
4. DATE OF DEATH: Month October — Day 27 — Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 25, 1880
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months 6 — Days 2
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Proprietor - Shoe Store....
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ITALY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carmelo Borzi
14. MOTHER'S MAIDEN NAME: Agata Navarria

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: Mrs. A. Borzi (Wife), 1604 Buchanan St. N.W. - D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hemorrhage, Cerebral — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Hypertension — DUE TO — 5 yrs
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 10 19 56 to Oct 27 19 56 that I last saw the deceased alive on Oct 27 19 56, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: A.W. Smith M.D.
ADDRESS (Street, city or town, state): 1601 16th St. NW Washington, D.C.
DATE SIGNED: 10/27/56
PHYSICIAN'S NAME (Type): A.W. SMITH

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/30/1956
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
22d. LOCATION (City, town, or county) (State): SUITLAND, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: R. Martin Hysong Co.
ADDRESS: 1300-N ST N W Wash. D.C.
24a. DATE RECEIVED BY REGISTRAR: OCT 31 1956
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1044 — 10405 — Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville R-2
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): J. Lock Rd

2 USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berwyn R-2
d. STREET ADDRESS: J. Locke Rd
e. RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Ernest — Middle: — Last: Brown
4. DATE OF DEATH: Month: Oct — Day: 15 — Year: 1956
5. SEX: Male
6. COLOR OR RACE: C.W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-15-1884
9. AGE (In years last birthday): 72 YRS.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labr
10b. KIND OF BUSINESS OR INDUSTRY: I.A.H.
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary E. Brown (wife) Address: Rockville #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.):
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Bischoff M.D.
EXAMINER'S NAME (Type): FRANK J. BISCHOFF
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-15-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/20/56
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial
22d. LOCATION (City, town, or county): Suitland (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Rockville, Md. Robert Snowden — ADDRESS:
24a. REC'D BY REGISTRAR DATE: 10/22/56
24b. REGISTRAR'S SIGNATURE: Laurell Kraglow per EC

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15M6(5)
SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10442

CERTIFICATE OF DEATH

10406

Reg. Dist. No. 9-17

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 3 days.
d. NAME OF HOSPITAL OR INSTITUTION: Montgomery County General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville Rt #3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First: Jessie — Middle: Wrenn — Last: Carroll

4 DATE OF DEATH: Month: October — Day: 21 — Year: 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/14/01
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Louis I Wrenn
14. MOTHER'S MAIDEN NAME: Irene Graves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Address: Hospital records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Congestive heart failure	5 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Hypertensive cardiovascular disease	10 yrs
DUE TO (c)	Diabetes mellitus	15 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 19 56 to Oct 19 56, that I last saw the deceased alive on Oct 20 19 56, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A D Bonyun M.D.
ADDRESS (Street, city or town, state): Sandy Spring, Md.
DATE SIGNED: 10/21/56
PHYSICIAN'S NAME (Type): A. D. BONIFANT

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct. 23, 1956
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince George's Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey
ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: 10-22-56
24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hosp tal or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician on page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10443

10407

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 16: 3½ yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2614 URBANA DRIVE

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 2614 URBANA DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ANNA — Middle LUCILLE — Last CARTER

4 DATE OF DEATH: Month OCTOBER — Day 6 — Year 1956

5 SEX: FEMALE

6 COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 11/14/83

9 AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11 BIRTHPLACE (State or foreign country): AUGUSTA, GEORGIA

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM DAVIDSON

14. MOTHER'S MAIDEN NAME: FLORENCE DAVIDSON

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)

16 SOCIAL SECURITY NO.: 705-12-1654B

17 INFORMANT: Mr. Joseph L. Carter, 2614 Urbana Drive, Silver Spring, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. p. m., Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 50, to Oct. 6, 19 56, that I last saw the deceased alive on Oct 6, 19 56, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Margaret T. Snow M.D. — ADDRESS (Street, city or town, state): 9013 Flower Ave Silver Sp — DATE SIGNED: Oct. 7, 1956

PHYSICIAN'S NAME (Type): Margaret T. Snow, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 9, 1956

22c. NAME OF CEMETERY OR CREMATORY: Monocacy Cemetery

22d LOCATION (City, town or county) (State): Beallsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Warner C. Pumphrey — ADDRESS: Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: 10/9/56

24b. REGISTRAR'S SIGNATURE: Frances Potter

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10444

CERTIFICATE OF DEATH

10408

Reg. Dist. No. 217

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Sharon C. H. Konic Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2600 17th St N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Sadie — Middle: G — Last: Chapin

4. DATE OF DEATH: Month: Oct. — Day: 27 — Year: 1956

5 SEX: F

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Oct. 31, 1880

9 AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS: Months | Days | Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Ont. Canada

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Heath

14. MOTHER'S MAIDEN NAME: Helen S Want

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT: Address: Pt's Admission Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardio respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Chronic Myocar d. dis — 2 mos.

DUE TO

(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Cystitis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 4, 19 56 to Oct 27, 19 56 that I last saw the deceased alive on Oct 26, 19 56, and that death occurred at 2 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): Sandy Spring Md.

DATE SIGNED: 10/27/56

PHYSICIAN'S NAME (Type): E. H. LIGON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/30/56

22c. NAME OF CEMETERY OR CREMATORY: National Washington Cemetery

22d. LOCATION (City, town, or county) (State): Prince Georges Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Company

ADDRESS: Arlington, Va.

24a. REC'D BY REGISTRAR DATE: 10-28-56

24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (d) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10445

CERTIFICATE OF DEATH

10409

Reg. Dist. No 2 1b

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Dist of Col. b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda

c. LENGTH OF STAY IN 1b 2 days

c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.

d. STREET ADDRESS 7809 14th St N.W

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Jennie Middle O'boughlin Last Cleary

4 DATE OF DEATH Month Oct. Day 26 Year 1956

5 SEX Female

6. COLOR OR RACE White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Sept. 4 1878

9 AGE (In years last birthday) 78 yrs.

IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS: Hours, Min.

10a USUAL OCCUPATION Give kind of work done during most of working life (even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Connecticut

12 CITIZEN OF WHAT COUNTRY USA.

13. FATHER'S NAME Patrick O'boughlin

14 MOTHER'S MAIDEN NAME ? Harvey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT Address Grace Talbot - above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 7 days

331x

DUE TO (b) Hypertension — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 34.0 x

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). Diabetes mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1953 to 2 Oct 1956, that I last saw the deceased alive on 25 Oct, 1956, and that death occurred at 7.15 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE William D Aud M.D. ADDRESS (Street, city or town, state) 9006 Colesville Rd Silver Spring Md DATE SIGNED 11/2/56

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF Oct. 30/1956

22c. NAME OF CEMETERY OR ~~CREMATORY~~ St. James

22d LOCATION (City, town, or county) (State) Naugatuck, Conn

23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS 3821-14th St. N.W. Wash. DC

24a REC'D BY REGISTRAR DATE 10-29-56

24b REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Ltr 8 Film 3205

.10446

10410

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1 a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montg.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norbeck

c. LENGTH OF STAY IN 1b: 3 months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bradford Rest Home

d. STREET ADDRESS: 3911 Hampden St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First [redacted] Middle Kendrick Last Cohen

4. DATE OF DEATH: Month 10 Day 12 Year 56

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/9/1877 1870

9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carlonia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Willis Cohen

14. MOTHER'S MAIDEN NAME: Sarah Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 22 407 9607

17. INFORMANT: Mrs Lillie Cohen Address: 3911 Hampden St. Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Nephritis Chronic — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Hypertensive Cardiorenal Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 28 19 56 to Oct. 12, 56 19, that I last saw the deceased alive on Oct. 11 56 19, and that death occurred at 4:50 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Webster Sewell M.D. ADDRESS (Street, city or town, state): Norbeck R.F.D. DATE SIGNED: 10.15.56

PHYSICIAN'S NAME (Type): Webster Sewell, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/15/56

22c. NAME OF CEMETERY OR CREMATORY: Ash Memorial

22d. LOCATION (City, town or county) (State): Sandy Spring, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Sunderland ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: 10-16-56

24b. REGISTRAR'S SIGNATURE: Gertrude B. Fowler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

Page 4

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10405

10411

CERTIFICATE OF DEATH

Reg Dist. No. 7/23

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: D. C. — b COUNTY:

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c LENGTH OF STAY IN 1b: 3 yrs.

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cedar Haven Rest Home

e STREET ADDRESS: 1301 Ridge Place SE.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruby — Middle: R — Last: Corcoran

4 DATE OF DEATH: Month: Oct — Day: 15th — Year: 1956

5 SEX: Fe

6 COLOR OR RACE: Cauc

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Feb 17-1880

9 AGE (In years last b'rthday): 76 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Rutty

14. MOTHER'S MAIDEN NAME: Anna Grissold

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: Address: Mrs. H. Corcoran 1301 Ridge Place S.E.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerosis, Generalized, with cerebral anoxia — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1956 to October 15, 1956 that I last saw the deceased alive on October 15, 1956, and that death occurred at 8:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: J. M. Whitlock M.D. — ADDRESS (Street, city or town, state): 7201 Carroll ave Takoma Park, md — DATE SIGNED

PHYSICIAN'S NAME (Type): J. M. Whitlock, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Oct 18-56 — 22c. NAME OF CEMETERY OR CREMATORY: Arlington National — 22d LOCATION (City, town, or county) (State): Arlington Va

23. FUNERAL DIRECTOR'S SIGNATURE: Sentman Bros. — ADDRESS: 1661 H Hope Rd SE Washington DC

24a. REC'D BY REGISTRAR — DATE: OCT 18 1956

24b REGISTRAR'S SIGNATURE: J. Nelson Noddy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10447

CERTIFICATE OF DEATH

10412

Reg. Dist. No. 216

1 PLACE OF DEATH
a COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN 1b: 1 MONTH
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: NEW JERSEY — b COUNTY: CAMDEN
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): GLOUCESTER
d STREET ADDRESS: 815 MONMOUTH ST
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET — Middle B — Last COSTELLO
4 DATE OF DEATH: Month 10 — Day 15 — Year 1956
5 SEX: F
6. COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: JULY 26 1901
9 AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY: NO
11 BIRTHPLACE (State or foreign country): CAMDEN, NEW JERSEY
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: JOHN J BURKE
14 MOTHER'S MAIDEN NAME: O CONNOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO:
17 INFORMANT: THOMAS A INGLESBY — Address: CHEVY CHASE, MD 4609 WILLARD AVE

MED. CA. CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
DUE TO (b): Carcinoma Bowel — 11 mo.
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): INANITION CACHEXIA Blockage of Ureters due to (a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a. m. p. m. — Month, Day, Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1, 1956 to Oct. 15, 1956, that I last saw the deceased alive on 10/15, 1956, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Egbert T. Phelps M.D. — ADDRESS (Street, city or town, state): 3409 SCARSDALE RD — DATE SIGNED:
PHYSICIAN'S NAME (Type): EGBERT T PHELPS — WASH 16 DC

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 10/19/56
22c NAME OF CEMETERY OR CREMATORY: New St Marys
22d LOCATION (City, town or county) (State): Bellmawr N.J.

23 FUNERAL DIRECTOR'S SIGNATURE: J. William Leitz — ADDRESS: 300-4 St N.E. D.C.
24a. REC'D BY REGISTRAR DATE: 10-18-56
24b REGISTRAR'S SIGNATURE: Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10413 (10415) Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7918 Sleaford ~~Road~~ Place Home

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 7918 Sleaford ~~Road~~ Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EARL — Middle A. — Last COX
4. DATE OF DEATH: Month October — Day 7, — Year 19 56
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 22, 1888
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months 9 Days 15 — IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. - Fireman
10b. KIND OF BUSINESS OR INDUSTRY: Fire Fighter
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?: US
13. FATHER'S NAME: James L. Cox
14. MOTHER'S MAIDEN NAME: G. M. Scaggs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Julia Cox- Item # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I[a]

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐

ACTUAL SIGNATURE: [signature] M.D
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/7/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/10/56
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county) (State): Prince George Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 10-8-56
24b. REGISTRAR'S SIGNATURE: Bennie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word 'pending' in pencil in Item 18. Give Pages 1 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or cremation or removal.

VS. A1SME(5) 5M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10449

CERTIFICATE OF DEATH

10414
Reg. Dist. No. 215.

1 PLACE OF DEATH
a COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda, (Rural)
c LENGTH OF STAY IN 1b: 5 min
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Naval Hospital, Bethesda, Md.

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a STATE: MARYLAND — b COUNTY:
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d STREET ADDRESS: 1217 Allison Drive
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Timothy — Middle: James — Last: DARRAGH
4. DATE OF DEATH: Month: October — Day: 2 — Year: 1956

5 SEX: Male
6 COLOR OR RACE: Caucasian
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Oct. 2, 1956
9 AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: 5

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James J. DARRAGH
14. MOTHER'S MAIDEN NAME: Marilyn E. WAHLE

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --
16 SOCIAL SECURITY NO: None
17 INFORMANT: (Father) James J. DARRAGH (Same as #?) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Failure to establish respiration — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO
16X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c) Immaturity

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour: a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I attended the deceased from 2 Oct. 1956 to 2 Oct. 1956 that I last saw the deceased alive on 2 Oct. 1956, and that death occurred at 2.57 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Mazur M.D. ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. DATE SIGNED: 10-3-56
PHYSICIAN'S NAME (Type): John H. Mazur, LT, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-9-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: R. A. Pumphery Sr
ADDRESS: Bethesda, Md.
R. A. Pumphery Funeral Home, 7557 Wisconsin Ave
24a. REC'D BY REGISTRAR DATE: 10-2-56
24b. REGISTRAR'S SIGNATURE: Mary E. Donnelly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10450

CERTIFICATE OF DEATH

10415

Reg. Dist. No. 216

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1 55 10M

1. PLACE OF DEATH

COUNTY: MONTGOMERY — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE

LENGTH OF STAY (in this place): 26 Yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5608 WESTERN AVENUE

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: MARYLAND COUNTY: MONTGOMERY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE

STREET ADDRESS (If rural give location): 5608 WESTERN AVENUE

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) MARY (Last) DASHIELL

4. DATE OF DEATH: (Month) 10 (Day) 26 (Year) 1956

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: 5/24/1868

9. AGE last birthday: 88 yrs. (IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENN.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JACKSON D. STONEROAD

14. MOTHER'S MAIDEN NAME: JANE A. McKEE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.): NO (If Yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO: NONE

17. INFORMANT & ADDRESS: DOROTHY D. ACORN 5608 WESTERN AVENUE, MD.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.

ANTECEDENT CAUSE(S) DUE TO (B): Arteriosclerotic heart dis. — 2+ yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Hemorrhagic cystitis — 4+ wks.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER—NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) Day, (Year) (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify, that I attended the deceased from Sept 5, 1952 to Oct 26, 1956, that I last saw the deceased alive on Oct 25, 1956, and that death occurred at 9:40 P.M., from the causes and on the date stated above

SIGNATURE: A. A. Richwine, M.D.

ADDRESS (Street, city, town, state): 5522 Western Ave Chevy Chase Md

DATE SIGNED: Oct 26 1956

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county) (State)
Burial	10/29/56	Glenwood Cemetery	Washington, D. C.

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE 10-29-56	Bessie M. Thompson	The S. H. Hines Company	2901 14th St Washington, D. C.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10451

10416

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b: Since 9/18/56
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: KENSINGTON GARDENS NURSING HOME

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
d. STREET ADDRESS: 3000 MCCOMAS AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ELSA Middle MYRTLE Last DAVIS

4 DATE OF DEATH: Month OCTOBER Day 9 Year 1956

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JUNE 29, 1868
9 AGE (In years last birthday): 88 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED HOMEMAKER
10b KIND OF BUSINESS OR INDUSTRY: OWN HOME
11 BIRTHPLACE (State or foreign country): CLARKSBURG, INDIANA
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: UNKNOWN MARSHALL
14. MOTHER'S MAIDEN NAME: HARRIETT BOWLING

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16 SOCIAL SECURITY NO: NONE
17 INFORMANT: Address: MRS. FRANKLIN B. MADES, 3518 NIMITZ RD., KENSINGTON, (MD.)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Malnutrition	1 wk.
DUE TO (b)	Metastatic Carcinoma	1 yr +
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Adenocarcinoma of colon	2 yr +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1954 to Sept 18, 1956, that I last saw the deceased alive on 9/18, 1956, and that death occurred at 7:05 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James R Coleman M.D.
ADDRESS (Street, city or town, state): 113 Carroll St NW Washington DC
DATE SIGNED: 10/9/56
PHYSICIAN'S NAME (Type): JAMES R. COLEMAN

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: OCT. 13, 1956
22c NAME OF CEMETERY OR CREMATORY: GEORGE WASHINGTON MEMORIAL
22d LOCATION (City, town, or county) (State): PRINCE GEORGE'S CO., MARYLAND

23 FUNERAL DIRECTOR'S SIGNATURE: Julian E. Humphrey
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 10/9/56
24b REGISTRAR'S SIGNATURE: Frances Cottier

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician on
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event with in 72 hours after death.

Medical examiner notified (Frank L. Blaschcak) 4 pm 10/9/56 me to sign certificate James Coleman MD

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10452

CERTIFICATE OF DEATH

10417

Reg. Dist No. 212

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Poolesville — c. LENGTH OF STAY IN 1b: Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville — Rural
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Hughes Road	d. STREET ADDRESS: Hughes Road — e. IS RESIDENCE ON A FARM? YES [x] NO [ ]

3. NAME OF DECEASED (Type or print) First / Middle / Last: Davis, Lawrence Preston	4. DATE OF DEATH Month / Day / Year: Oct – 15 – 1956
5. SEX: Male	6. COLOR OR RACE: Colored
7. MARRIED [ ] NEVER MARRIED [x] WIDOWED [ ] DIVORCED [ ]	8. DATE OF BIRTH: Feb – 28 – 1912
9. AGE (In years last birthday): 44 yrs	IF UNDER 1 YEAR Months: 7 Days: 19 — IF UNDER 24 HRS Hours: — Min: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer	10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Poolesville, Md	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Jessa Holland	14. MOTHER'S MAIDEN NAME: Rosie Lee Davis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No	16. SOCIAL SECURITY NO: 214-18-8252
17. INFORMANT / Address: Anna Louise Brunson, Poolesville, Md	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): acute heart failure (acute distress?) — INTERVAL BETWEEN ONSET AND DEATH: 4½ hours

DUE TO (b): High Arterial Tension — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [x]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. — 20d. INJURY OCCURRED While at work [ ] Not while at work [ ] — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 – 15, 1956, to Oct. 15, 1956, that I last saw the deceased alive on Oct. 15, 1956, and that death occurred at 12 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Miller M.D. — ADDRESS (Street, city or town, state): ... — DATE SIGNED: ...

PHYSICIAN'S NAME (Type): WILLIAM C. MILLER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 10/18/56
22c. NAME OF CEMETERY OR CREMATORY: Elijah	22d. LOCATION (City, town, or county) (State): Poolesville, Md
23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert L. Snowden – Rockville, Md	24a. REC'D BY REGISTRAR DATE: 10/19/56
24b. REGISTRAR'S SIGNATURE: Charles A. Elgin per L.K.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retu[redacted] the hospital or attending physician.
TO FUNERAL [redacted]OR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10453

CERTIFICATE OF DEATH

10418

Reg. Dist. No. 216

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a STATE: Maryland — b COUNTY: Montgomery

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase

c LENGTH OF STAY IN 1b

c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): ~~Chase~~ Chevy Chase

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3915 Underwood Street

d STREET ADDRESS: 3915 Underwood Street

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First AUSTIN Middle P. Last DeWILLE, Sr.

4 DATE OF DEATH: Month October Day 11, Year 1956

5 SEX: Male — 6 COLOR OR RACE: White — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: July 5, 1906

9 AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months 3 Days 6 — IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Broker

10b KIND OF BUSINESS OR INDUSTRY: Brokerage

11 BIRTHPLACE (State or foreign country): New York

12 CITIZEN OF WHAT COUNTRY? Us

13 FATHER'S NAME: George C. DeWilde

14 MOTHER'S MAIDEN NAME: Marion Hutchison

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO: Unknown

17 INFORMANT: Louise B. DeWilde- Item # 2 — Address

18/ CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, colon (sigmoid)
DUE TO (b): with generalized carcinomatosis, abdominal
DUE TO (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 19 55 to Oct. 11, 19 56 that I last saw the deceased alive on Oct. 10, 1956, and that death occurred at 11:40 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip H. Varner, M.D. — ADDRESS (Street, city or town, state): 7702 Conn. Ave, Chevy Chase, Md. — DATE SIGNED: 10/11/56

PHYSICIAN'S NAME (Type): Philip H. Varner

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 10-13-56

22c. NAME OF CEMETERY OR CREMATORY: Parklawn

22d LOCATION (City, town, or county) (State): Rockville, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey- Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 10-15-56

24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10454 **CERTIFICATE OF DEATH** Reg. Dist No. 10419

1 PLACE OF DEATH
a COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON
c LENGTH OF STAY IN 1b 6 YRS.
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3112 EDGEWOOD ROAD

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE MARYLAND b COUNTY MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON
d. STREET ADDRESS 3112 EDGEWOOD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First RCSA Middle CATHERINE Last DIXON

4 DATE OF DEATH Month OCTOBER Day 18 Year 1956

5. SEX FEMALE
6. COLOR OR RACE WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH 10/14/84
9 AGE (In years last birthday) 72 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical
10b. KIND OF BUSINESS OR INDUSTRY Southern Railway Woodward & Lothrop
11 BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE KNORLEINE
14. MOTHER'S MAIDEN NAME MARY WINDHAM

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-20-2363
17 INFORMANT Address Mr. Laurence E. Dixon, 3112 Edgewood Road Kensington, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH 1 hr

DUE TO

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Chronic Congestive Heart Failure — many years

DUE TO

(c) Progressive Heart Disease — Unknown

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 1-19 19 54, to 10-18 19 56, that I last saw the deceased alive on 10-16 19 56, and that death occurred at 2:22 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE [signature] M.D. ADDRESS (Street, city or town, state) 11602 Georgia Ave. DATE SIGNED 10-18-56

PHYSICIAN'S NAME (Type) Morris Ferris M.D. Silver Spring Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 10/22/56
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY
22d. LOCATION (City, town or county) (State) WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, ADDRESS SILVER SPRING, MARYLAND
24a REC'D BY REGISTRAR DATE 10/23/56
24b REGISTRAR'S SIGNATURE [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10455

CERTIFICATE OF DEATH

10420

Reg. Dist. No 217

1 PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Olney
c. LENGTH OF STAY IN 1b 16 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
d. STREET ADDRESS 6825 Red Top Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Margaret Middle Petty Last Dodge

4 DATE OF DEATH Month Oct. Day 24 Year 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Sept 25 1878
9. AGE (In years last birthday) 78 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Anacostia D.C.
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME Henry S. Petty
14. MOTHER'S MAIDEN NAME Margaret Hodges

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO none
17. INFORMANT Harry P. Dodge Address Batchelors Forest Olney Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 4 days

DUE TO (b) Fibroid Myocardial degeneration — 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Senile debility — 1 year

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 19 53 to Oct, 19 56 that I last saw the deceased alive on Oct 22, 19 56, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE [signature] M.D. Olney, Md. 10-27-56

PHYSICIAN'S NAME (Type) H. D. Bonifant

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 10/27/56
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY
22d. LOCATION City, town, or county) PRINCE GEORGE COUNTY, (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey ADDRESS 8434 Georgia Ave Silver Spring, Md
24a. REC'D BY REGISTRAR DATE 10-28-56
24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physic an
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10406

CERTIFICATE OF DEATH

10421

Reg. Dist No. 2-23

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 3 WEEKS
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: WASHINGTON SANITARIUM HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): KENSINGTON
d. STREET ADDRESS: 3612 LITTLEDALE RD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLOTTE Middle ELIZABETH Last ELLIN

4. DATE OF DEATH: Month 10 Day 26 Year 1956

5. SEX: F

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4/23/79

9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Washington DC

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN EDWARD MORAN

14. MOTHER'S MAIDEN NAME: SUSAN V. SAINT LOUISS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: JOHN HENRY KARATZ — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): UREMIA AND CEREBROVASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 21 DAYS

DUE TO

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE — LONG STANDING

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NO INJURY

20c. TIME OF INJURY Month ___ Day ___ Year ___ Hour ___ A.M. / P.M. 1155 P.M. 10/26 1956

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 1956, to 10/26/56, 1956 that I last saw the deceased alive on 10/25/56, and that death occurred at 1155 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 1611 Cordage Ave Silver Spring, Md — DATE SIGNED: 10/26/56

PHYSICIAN'S NAME (Type): HENRY W STAUT MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/29/56

22c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY

22d. LOCATION (City, town or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Harold G. Lewis Inc. — ADDRESS: 1314 Georgia Ave Silver Spring Md.

24a. RECEIVED BY REGISTRAR DATE: 10/29/56

24b. REGISTRAR'S SIGNATURE: [signature] Deputy

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10427 — Reg. Dist. No. 10422

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: Monroe St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDWARD — Middle: J — Last: FARRELLY

4 DATE OF DEATH: Month: 10 — Day: 25 — Year: 1956

5. SEX: M — 6. COLOR OR RACE: W — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 18 1895

9 AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months: 0 — Days: 7 — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer
10b KIND OF BUSINESS OR INDUSTRY: Government
11 BIRTHPLACE (State or foreign country): Pennsylvania
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas F. Farrelly
14 MOTHER'S MAIDEN NAME: Mathilda Hermann

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO: No
17 INFORMANT: Wife — Address: same

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemopericardium — INTERVAL BETWEEN ONSET AND DEATH: 2 minutes

DUE TO: 420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Ruptured myocardial infarct, posterior — 2 days

(c) Thrombosis distal right coronary — 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 19 4 to Oct 23 1956, that I last saw the deceased alive on Oct 23 1956, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A D Daughton M.D. — ADDRESS (Street, city or town, state): 917 20th St NW — DATE SIGNED: 10/25/56

PHYSICIAN'S NAME (Type): A. D. DAUGHTON — Washington 6 D.C.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial-Jr. — 22b. DATE THEREOF: 10-25-56 — 22c. NAME OF CEMETERY OR CREMATORY: St. Marys — 22d LOCATION (City, town, or county): Mercer (State): Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Murphrey — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 10/26/56 — 24b. REGISTRAR'S SIGNATURE: Laurel Kraglund per E.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event with in 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10407 (10423) Reg. Dist No 223

CERTIFICATE OF DEATH

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 7 days
d. NAME OF HOSPITAL (If not in hospital give street address OR INSTITUTION) Washington Sanitarium Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 1001 Merrimack Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Ida Middle (None) Last Fleitell
4 DATE OF DEATH Month Oct. Day 1 Year 1956

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3-4-77?
9 AGE (In years last birthday) 80 yrs
IF UNDER 1 YEAR Months 7 Days
IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife
10b KIND OF BUSINESS OR INDUSTRY None
11 BIRTHPLACE (State or foreign country) Russia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Joseph Portnow
14. MOTHER'S MAIDEN NAME Bessie (unknown)

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -
16 SOCIAL SECURITY NO NONE
17 INFORMANT Mary C. Clarke RN Address 9107 Flower Ave, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple pulmonary emboli 4 days
DUE TO (b) Auricular fibrillation 2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c) Arteriosclerotic heart disease 20 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 9-23 19 56 to 10-1 19 56 that I last saw the deceased alive on Oct 1, 19 56, and that death occurred at 4:12 P.M. from the causes and on the date stated above
ACTUAL SIGNATURE Benjamin Manchester M.D. ADDRESS (Street city or town, state) 3200-16 st nw DATE SIGNED
PHYSICIAN'S NAME (Type) BENJAMIN MANCHESTER

22a BURIAL, CREMATION, REMOVAL (Specify) 22b DATE THEREOF Oct 4 '56
22c NAME OF CEMETERY OR CREMATORY Nat'l Mem. Park
22d LOCATION (City, town, or county) FALLS CHURCH (State) VA

23 FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home ADDRESS 4217 9th St NW DC
24a REC'D BY REGISTRAR DATE 10/4/56
24b REGISTRAR'S SIGNATURE Hilton Cook

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Funeral Director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10456

10424

CERTIFICATE OF DEATH

Reg. Dist No 216

1 PLACE OF DEATH a. COUNTY Montgomery — MARYLAND
Resmor Sanitarium Bethesda
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Resmor Sanitarium

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Montg.
7116 Western Ave Chevy Chase Md.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase
d. STREET ADDRESS Bethesda Md. 5721 Grosvenor Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Clarence Middle: Flickinger Last:
4. DATE OF DEATH Month: Oct. Day: 26 Year: 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 20th July 1874
9. AGE (In years last birthday) 82 yrs
IF UNDER 1 YEAR Months: 3 Days: 6 IF UNDER 24 HRS Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Self-emp.
10b. KIND OF BUSINESS OR INDUSTRY: Grocery Business
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob Flickinger
14. MOTHER'S MAIDEN NAME: Editha Weyrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Queenie Flickinger - Same Item #2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis with Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

DUE TO (b) Arteriosclerosis, general — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Arteriosclerotic Heart Disease — 2 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG. 5, 1955 to OCT. 26, 1956 that I last saw the deceased alive on Oct 25, 1956, and that death occurred at 2:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Leo M. Curtis M.D. ADDRESS (Street, city or town, state) 8218 Wisconsin Ave., Bethesda, Md DATE SIGNED 10/26/56

PHYSICIAN'S NAME (Type) LEO M. CURTIS M.D. 8218 WISCONSIN AVE., BETHESDA, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit
22b. DATE THEREOF 10/27/56
22c. NAME OF CEMETERY OR CREMATORY Rose Hill
22d. LOCATION (City, town, or county) Akron (State) OHIO

23. FUNERAL DIRECTOR'S SIGNATURE Walt. A. Pumphrey ADDRESS 7557 Wisconsin Ave
24a. REC'D BY REGISTRAR DATE 10/30/56
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4) 1SM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10457

10425

CERTIFICATE OF DEATH

Reg. Dist No. 216

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 16: 2 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 11015 Cone Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Leo — Middle: — Last: FRIEDBERG

4 DATE OF DEATH: Month: October — Day: 1 — Year: 1956

5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/15/04
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist
10b. KIND OF BUSINESS OR INDUSTRY: Drug
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph
14. MOTHER'S MAIDEN NAME: Ida Trilling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: 090-10-3201
17. INFORMANT: GERTRUDE FRIEDBERG — Address: 11018 Cone Lane SS/P

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO: Uric
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO:
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Emphysema, Terminal, Post Surgery
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-2, 19 56, to 10-1, 19 56, that I last saw the deceased alive on 10-1, 19 56, and that death occurred at 7 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas Berry, M.D. — ADDRESS (Street, city or town, state): 11602 Georgia Ave — DATE SIGNED: 10-2-56

PHYSICIAN'S NAME (Type): Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/3/56
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Mem Cem
22d. LOCATION (City, town, or county) (State): Rockville, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Goldburg Funeral Home — ADDRESS: 4217 9th St. NW Wash DC
24a. REC'D BY REGISTRAR DATE: 10-4-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10458

CERTIFICATE OF DEATH

10426

Reg Dist No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE — b COUNTY

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Nursing Home

d. STREET ADDRESS: 1614 Myrtle St. N.W.

e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First DAISY Middle BELLE Last FRENHEISER

4. DATE OF DEATH: Month Oct. Day 6 Year 1956

5 SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 10/17/1871

9 AGE (In years last birthday): 84 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Marshall Seymour

14 MOTHER'S MAIDEN NAME: Mary Hendrei Pounded

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT: Elizabeth Neely — Address: 1614 Myrtle St N W

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Generalized Arteriosclerosis — 8 yrs.

DUE TO

(c):

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from August 19 48 to Oct 6 1956, that I last saw the deceased alive on Oct 5 1956, and that death occurred at M, from the causes and on the date stated above

ACTUAL SIGNATURE: William T. Saccardi M.D. — ADDRESS (Street, city or town, state): 1150 Conn Ave Wash 6 DC — DATE SIGNED: 10/6/56

PHYSICIAN'S NAME (Type): William T. SACCARDI

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10/9/56

22c. NAME OF CEMETERY OR CREMATORY: West End Cemetery

22d. LOCATION (City, town, or county) (State): Pottstown, Pa.

23 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company — ADDRESS: 2901 14th St. N.

24a. REC'D BY REGISTRAR DATE: 10-9-56

24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10427

10408

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1 PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park

c. LENGTH OF STAY IN 1b: 1½ days

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Walsh San. Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Pennsylvania — b. COUNTY Schuylkill

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mahanoy

d. STREET ADDRESS: 201 W. Centre St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Frank — Middle — Last Galati

4 DATE OF DEATH: Month Oct. — Day 6 — Year 19 56

5 SEX: Male

6 COLOR OR RACE: White ~~Italian~~

7 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 3-25-90

9 AGE (In years last birthday): 66 yrs

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction work

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Italy

12 CITIZEN OF WHAT COUNTRY? American

13 FATHER'S NAME: Nicholas Galati

14 MOTHER'S MAIDEN NAME: Lotorto

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service):

16 SOCIAL SECURITY NO: Unknown

17 INFORMANT — Address: Walsh San. Records — White

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial infarction

DUE TO (b): Intractable heart disease

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: (a) 2 days; (b) 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month — Day — Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10-4, 19 56, to 10-6, 19 56, that I last saw the deceased alive on 10-6, 19 56, and that death occurred at 12:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas H Wilson M.D.

ADDRESS (Street, city or town, state): 7401 Eastern Ave. Md. 10/6/56

DATE SIGNED

PHYSICIAN'S NAME (Type): Chas H Wilson

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 10/7/56

22c. NAME OF CEMETERY OR CREMATORY

22d LOCATION (City, town, or county) (State): Shenandoah, Pa

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.

ADDRESS: 1400 Chapin Ct. NW

24a. REC'D BY REGISTRAR DATE: 10/10/56

24b REGISTRAR'S SIGNATURE: Hilton Roth

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10409 10420

Reg. Dist. No. 222

1 PLACE OF DEATH a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 30 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 12 MONTGOMERY AVE

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: 12 MONTGOMERY AVE
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ROBERT Middle C. Last GARBER
4. DATE OF DEATH: Month OCT. Day 20, Year 1956.

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT. 20, 1880
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. TELEGRAPHER
10b. KIND OF BUSINESS OR INDUSTRY: POSTAL TELEGRAPH
11. BIRTHPLACE (State or foreign country): SANGERSVILLE, VA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DANIEL H. GARBER
14. MOTHER'S MAIDEN NAME: AMANDA JANIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: ROBERT C. GARBER, JR. Address: TAKOMA PARK, MD. 12 MONTGOMERY AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO (b): Cancer of the lung — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 25, 1955, to 10-20-, 1956, that I last saw the deceased alive on 10-17-, 1956, and that death occurred at 7.45 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Efrain Guerrero M.D. 901 20th St. N.W. Wash. D.C.
PHYSICIAN'S NAME (Type): EFRAIN GUERRERO
ADDRESS (Street, city or town, state) DATE SIGNED: OCT 20 56

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Oct 22, 1956
22c. NAME OF CEMETERY OR CREMATORY: NATIONAL MEMORIAL PARK
22d. LOCATION (City, town, or county) (State): FALLS CHURCH, VA

23. FUNERAL DIRECTOR'S SIGNATURE: Alastair Fallas
ADDRESS: TAKOMA PARK D.C. 254 CARROLL STREET
24a. REC'D BY REGISTRAR DATE: 10/22/56
24b. REGISTRAR'S SIGNATURE: Hilton Lodge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be related by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10429

Reg. Dist. No. 217

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND — 10459
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 12 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Montgomery County General Hospital, Inc

2. USUAL RESIDENCE (Where deceased lived. If not in town Residence before admission) — a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksville
d. STREET ADDRESS: CEDAR LANE
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: George — Middle — Last: Gayleard
4. DATE OF DEATH: Month: October — Day: 17 — Year: 19 56

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 10/26/92
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or Foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Asbury Gayleard
14. MOTHER'S MAIDEN NAME: Pauline Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WWI
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT — Address: Hospital Record (Brother)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
T I K
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Coronary arteriosclerosis severe
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED — While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and find that death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ]

ACTUAL SIGNATURE: Frank J Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart, M. D.
CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 10/17/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-20-56
22c. NAME OF CEMETERY OR CREMATORY: St. Louis
22d. LOCATION (City, town, or county) (State): Clarksville, Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F.C. Higinbothom, Ellicott City, Md
24a. REC'D BY REG STRAR — DATE: OCT 18 1956
24b. REG STRAR'S SIGNATURE: Miranda Lashley

1

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(3)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10460 10430

CERTIFICATE OF DEATH

Reg. Dist. No. 16

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5 Knox Circle, S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: John — Middle: Mitchell — Last: Gill

4 DATE OF DEATH: Month: October — Day: 6 — Year: 1956

5 SEX: Male

6. COLOR OR RACE: Negro

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: June 2, 1914

9 AGE (In years last birthday): 42 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Press Operator U. S.

10b KIND OF BUSINESS OR INDUSTRY: Gov't. Printing Office

11 BIRTHPLACE (State or foreign country): North Carolina

12 CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Lafeytte Gill

14. MOTHER'S MAIDEN NAME: Lilly Mitchell

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: Unknown

17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): MYASTHENIC CRAVIS CRISIS — INTERVAL BETWEEN ONSET AND DEATH:

1440

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PULMONARY EDEMA, MILD

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from September 14, 1956, to October 6, 1956, that I last saw the deceased alive on October 6, 1956, and that death occurred at 6 A. M. from the causes and on the date stated above

ACTUAL SIGNATURE: Caswell K. Smith M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 10-6-56

PHYSICIAN'S NAME (Type): Caswell K. Smith, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify):

22b. DATE THEREOF: 10/11/56

22c. NAME OF CEMETERY OR CREMATORY:

22d. LOCATION (City, town, or county) (State):

23. FUNERAL DIRECTOR'S SIGNATURE:

ADDRESS:

24a. REC'D BY REGISTRAR — DATE:

24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10410

CERTIFICATE OF DEATH

10431

Reg. Dist. No. 223

1 PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 828 Berkshire Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Harry — Middle: — Last: Gordon

4. DATE OF DEATH: Month 10 — Day 15 — Year 196

5. SEX: Male
6. COLOR OR RACE: Jewish
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-17-09
9. AGE (In years last birthday): 47 yrs — IF UNDER 1 YEAR: Months — IF UNDER 24 HRS: Days, Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Evening Star - Circulation Dept
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Samuel Gordon
14. MOTHER'S MAIDEN NAME: Lena Schuman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Address: Hosp. Chart.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): MYOCARDIAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
DUE TO
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b): ACUTE MYOCARDIAL INFARCTION — 6 DAYS
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/11 19 56 to 10/15 19 56 that I last saw the deceased alive on 10/15 19 56, and that death occurred at 10:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Benjamin Isaacson M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED
PHYSICIAN'S NAME (Type) BENJAMIN ISAACSON M.D

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/16/56
22c. NAME OF CEMETERY OR CREMATORY: King David Memorial Gardens
22d. LOCATION (City, town or county) (State): Falls Church, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: B. Mazansky & Sons
ADDRESS: 3501 14th St. N.W.
24a. REC'D BY REGISTRAR DATE: 10/19/56
24b. REGISTRAR'S SIGNATURE: J. Wilson Poole

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10461

CERTIFICATE OF DEATH

10432

Reg Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland
c. LENGTH OF STAY IN 1b: 174 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Virginia — b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: RFD #1, Box 222, Fort Hunt Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: James — Middle: Virgil — Last: Gordon

4 DATE OF DEATH: Month: October — Day: 24, — Year: 19 56

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: August 21, 1920

9 AGE (In years last birthday): 36 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Railroad Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James Gordon

14. MOTHER'S MAIDEN NAME: Virgie Kidwill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes — WWII

16. SOCIAL SECURITY NO: 226-14-0895

17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hemorrhagic pneumonia, generalized — INTERVAL BETWEEN ONSET AND DEATH: 1 hr 4 hrs

DUE TO (b): Histoplasmic, endocarditis — 1 1/2 yr.

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 3, 1956 to October 24, 19 56 that I last saw the deceased alive on October 24, 1956, and that death occurred at 11.15P M. from the causes and on the date stated above

ACTUAL SIGNATURE: Richard K. Merchant M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED

PHYSICIAN'S NAME (Type): Richard K. Merchant, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/29/56

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City town or county) (State): ALEXANDRIA VA.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Cline — ADDRESS: 609 KING ST. ALEXANDRIA VA

24a. REC'D BY REGISTRAR DATE: 10-27-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10411

CERTIFICATE OF DEATH

10433

Reg. Dist. No. 243

1 PLACE OF DEATH a COUNTY MONTGOMERY MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK
c. LENGTH OF STAY IN 1b 37 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 513 PHILADELPHIA AVE.

2 USUAL RESIDENCE (Where deceased lived If institution, residence before admission)
a STATE Md b. COUNTY MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK
d. STREET ADDRESS 513 PHILADELPHIA
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First RALPH Middle EDGAR Last GOULD
4 DATE OF DEATH Month OCT Day 4 Year 1956

5. SEX M
6. COLOR OR RACE W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH DEC 10, 1886
9 AGE (In years last birthday) 69 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIST
10b KIND OF BUSINESS OR INDUSTRY US GOVT.
11 BIRTHPLACE (State or foreign country) MASS.
12 CITIZEN OF WHAT COUNTRY U S A

13. FATHER'S NAME EDGAR GOULD
14 MOTHER'S MAIDEN NAME CORA PARKER

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO 577-42-8328
17 INFORMANT EDNA C. GOULD Address TAKOMA PARK, MD 513 PHILADELPHIA AVE.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Coronary Thrombosis	1-2 hours.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (b)	Arteriosclerosis Generalized	10 years
DUE TO (c)		

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Coronary Thrombosis March 1956
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 10, 1956, to 4 Oct, 1956, that I last saw the deceased alive on 2 Oct 1956, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE H B Queen M.D.
ADDRESS (Street, city or town, state) 7112 Willow Ave
DATE SIGNED 4 Oct
PHYSICIAN'S NAME (Type) H. B QUEEN Takoma Park, Md 1956

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF Oct 6, 1956
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY
22d LOCATION (City, town, or county) BLADENSBURG Rd. PRGE. CO. (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE Walter D. Talbert ADDRESS TAK. PK. 254 CARROLL ST. N.W. D.C.
24b. REC'D BY REGISTRAR DATE 10/5/56
24c REGISTRAR'S SIGNATURE J. Wilson Todd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10434

CERTIFICATE OF DEATH

10462

Reg Dist. No 216

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland
c LENGTH OF STAY IN 1b: 11 days
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Virginia
b. COUNTY: Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria, Virginia
d STREET ADDRESS: Box 362, Route #3
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ethel Middle Gray Last Gregory

4 DATE OF DEATH: Month October Day 5 Year 1956

5. SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: December 26, 1908
9 AGE (In years last birthday): 47 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dietitian
10b KIND OF BUSINESS OR INDUSTRY: Unknown
11 BIRTHPLACE State or foreign country: North Carolina
12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: H. C. Shropshire
14. MOTHER'S MAIDEN NAME: Dollie Bondurant

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO: 230-20-7516
17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Abdominal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs

DUE TO

177.1

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

(b) small bowel obstruction — 1 yr.

DUE TO

(c) fecal fistula proximal to fistula — 14 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from September 24 1956, to October 5, 1956, that I last saw the deceased alive on October 5, 1956, and that death occurred at 10:00 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: A. Louis A. Dolyn Jr. M.D. ADDRESS (Street, city or town, state): National Cancer Institute DATE SIGNED

PHYSICIAN'S NAME (Type): David E. Nathan, M.D. Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 10-5-56
22c. NAME OF CEMETERY OR CREMATORY: Fairview Memorial Park
22d LOCATION (City town or county) (State): Alexandria Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Cunningham Funeral Home, Inc. ADDRESS:
24a. REC'D BY REGISTRAR DATE: 10-8-56
24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10435

10453

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 yrs.
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 6020 Delwood Rd

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X
d. STREET ADDRESS: 6020 Delwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LARION — Middle: A. — Last: GUENTHER

4. DATE OF DEATH: Month: October — Day: 4 — Year: 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 23, 1903
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months: 1 — Days: 11
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Poughkeepsie, N.Y.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Grante Smith
14. MOTHER'S MAIDEN NAME: Mary Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Walther Guenther — (Address) 6020 Delwood Road Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac Failure	4 hours
DUE TO (b)	Metastatic Carcinoma of Lung	5 Months
DUE TO (c)	Peptic Ulcer of the Heart	4 YEARS

Conditions (if any, which gave rise to immediate cause (a), stating the underlying cause last)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 1956, to Oct. 4, 1956, that I last saw the deceased alive on Oct 4, 1956, and that death occurred at 9:29 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robt G. Angle M.D. — M.D. — ADDRESS (Street, city or town, state): 5009 Del Ray Ave, Bethesda Md — DATE SIGNED: 10/5/56

PHYSICIAN'S NAME (Type): Dr. Robert G. Angle, 5009 DelRay Ave., Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial-Tr.
22b. DATE THEREOF: 10-5-56
22c. NAME OF CEMETERY OR CREMATORY: Poughkeepsie Rural Cem
22d. LOCATION (City, town, or county) (State): Poughkeepsie N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md
24a. REC'D BY REGISTRAR DATE: 10-6-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Humphrey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS AIS (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10436

CERTIFICATE OF DEATH

10464

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Alexandria

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda, 14, Md.

c. LENGTH OF STAY IN 1b: 129 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 3652 Gunston Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Davis — Middle: Fraser — Last: Hall

4. DATE OF DEATH: Month: October — Day: 1, — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1937

9. AGE (Last birthday): 19 yrs

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Milton Hall

14. MOTHER'S MAIDEN NAME: Helen Fraser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 230-68-9105

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Respiratory & Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Brainstem Compression.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Brain Tumor Unspecified Type. — 1/55.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 25, 1956 to October 1, 1956 that I last saw the deceased alive on October 1, 1956 and that death occurred at 6:30 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: John F. Lane M.D

ADDRESS (Street, city or town, state): The Clinical Center

DATE SIGNED: 10/1/56

PHYSICIAN'S NAME (Type): John F. Lane, M. D.

National Institutes of Health
Bethesda 14, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

22b. DATE THEREOF: 10/2/56

22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY

22d. LOCATION (City, town or county) (State): SUITLAND, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: WHEATLEY FUNERAL HOME 809 KING ST. ALEXANDRIA VIRGINIA

24a. REC'D BY REGISTRAR: DATE 10-4-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompkins

J. S. Cooley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10437

10465 **CERTIFICATE OF DEATH**

Reg. Dist. No. 214

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Maple Lane Nursing Home

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE: D.C. — b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. STREET ADDRESS: 7725 Terrace Rd. S.E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First CHRISTINE Middle Last HAMILTON

4. DATE OF DEATH: Month Oct. Day 24 Year 1956

5. SEX: Female

6. COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 23 1862

9 AGE (In years last birthday): 94 yrs

IF UNDER 1 YEAR Months 10 Days 1 — IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11 BIRTHPLACE (State or foreign country): Silver Hill, Md.

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Heigel

14 MOTHER'S MAIDEN NAME: Caroline Abendschein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. INFORMANT: Ann Boyd — Address: 7760 Rand Pl. N.E. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): HYPERTENSIVE HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Condition, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) CEREBRAL HEMORRHAGE

DUE TO

(c) ESSENTIAL HYPERTENSION

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): SENILITY

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT. 12, 1955 to Oct 24, 1956, that I last saw the deceased alive on Oct 24 1956, and that death occurred at 1:42 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Henry M. Lowndes M.D. — ADDRESS (Street, city or town, state): 5206 NORWAY DR. CHEVY CHASE, MD. — DATE SIGNED: Oct 24/1956.

PHYSICIAN'S NAME (Type): HENRY M. LOWNDES

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/27/56

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Brittand, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Nalley's Funeral Home, Inc. — ADDRESS: Mt. Rainier Md.

24a. RECEIVED BY REGISTRAR DATE: OCT 29 1956

24b. REGISTRAR'S SIGNATURE: Frances Keller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10466 16438

CERTIFICATE OF DEATH

Reg. Dist. No 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: 3 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6818 Delaware Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 6818 Delaware Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles — Middle Pennington — Last Hanback

4. DATE OF DEATH: Month October — Day 12 — Year 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/1/1872

9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Constructing

11. BIRTHPLACE (State or foreign country): Warrenton, Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Hanback

14. MOTHER'S MAIDEN NAME: Margaret Hitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOC AL SECURITY NO:

17. INFORMANT — Address: Charles W.Hanback,6818 Delaware St.D.C.Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 181x carcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 19 56 to Oct 12 19 56 that I last saw the deceased alive on Sept 15 19 56, and that death occurred at 9:10 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: Paul D. Cantor M.D.

ADDRESS (Street, city or town, state): 4709 Montgomery Lane Bethesda Md

DATE SIGNED: 10/12/56

PHYSICIAN'S NAME (Type): Paul D. Cantor

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 10/15/56

22c. NAME OF CEMETERY OR CREMATORY: Ft.Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Pr.Geo.Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The S. H. Hines Co., 2901 14th St. N.W. Wash,DC

24a. REC'D BY REGISTRAR DATE: 10-15-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10428

CERTIFICATE OF DEATH

10439

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE DC — b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ~~Residence~~ Congressional Manor ~~Sanitarium~~

d. STREET ADDRESS 5725 Utah Ave., N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: Ina Middle: Mabel Last: Hedges

4 DATE OF DEATH Month: October Day: 4 Year: 19 56

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/13/1881

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Casey, Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John C. Freeman

14. MOTHER'S MAIDEN NAME: Elizabeth Puffner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT — Address: Records at Congressional Manor Sanitarium

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 1/2 mos

DUE TO (b): Cerebral Arteriosclerosis — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 2, 1956 to Oct 4, 1956 that I last saw the deceased alive on Oct 4 19 56, and that death occurred at 6:25 A.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Robert B Hovell M.D. — ADDRESS (Street, city or town, state): 5515 Nebraska Ave — DATE SIGNED: 10-4-56

PHYSICIAN'S NAME (Type): Robert B Hovell — Washington, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/6/56

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St., N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR — DATE: OCT 5 1956

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10440

10457

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH
a COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c LENGTH OF STAY IN 1b: 6 YRS
d NAME OF HOSPITAL OR INSTITUTION: 9810 GEORGIA AVE.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: MARYLAND — COUNTY: BALTIMORE
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BALTIMORE
d STREET ADDRESS: 123 W. LAFAYETTE AVE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ANNA Middle FLORENCE Last HEWITT

4 DATE OF DEATH: Month OCT. Day 24 Year 1956

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 2-8-1872
9 AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months 8 Days 16
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11 BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN G. HOOK
14 MOTHER'S MAIDEN NAME: HENRIETTA ERICH

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17 INFORMANT: DOROTHY GRAHM Address: 5620 COLORADO AVE WASHINGTON, DC

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CUTE MYOCARDITIS — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): CHRONIC MYOCARDITIS
DUE TO (c): SENILITY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from MAY 5, 1956 to OCT. 24, 1956, that I last saw the deceased alive on OCT. 24 1956, and that death occurred at 3:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry Fowden M.D. ADDRESS (Street, city or town, state): 5206 NORWAY DATE SIGNED: OCT. 24/56
PHYSICIAN'S NAME (Type): HENRY M. FOWDEN CHEVY CHASE, MD.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/26/56
22c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT
22d. LOCATION (City, town, or county) (State): BALTIMORE, MD.

23 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. ADDRESS: 1400 Chapin St NW
24a. REC'D BY REGISTRAR DATE: 10/30/56
24b. REGISTRAR'S SIGNATURE: Francis Fowden

1 .

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death Page 4 may be released by the hospital or attending physician on ... funeral director
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filed in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10441

10458

CERTIFICATE OF DEATH

Reg. Dist. No 214

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE PENNSYLVANIA b COUNTY BLAIR

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON

c. LENGTH OF STAY IN 1b 1½ yrs. approx.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TYRONE

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium

d. STREET ADDRESS F. & M. BANK BUILDING XXXXXXXXXXXXXXXXXX

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Clement Middle S Last Hiltner

4. DATE OF DEATH Month 10 Day 21 Year 1956

5. SEX Male

6. COLOR OR RACE White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH Aug - 4 - 1871

9 AGE (In years last birthday) 85 yrs

IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) MAIL CLERK, RAILWAY

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) TYRONE, PENNSYLVANIA

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John A. Hiltner

14. MOTHER'S MAIDEN NAME Emma James

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO NONE

17 INFORMANT Robert C. Hiltner Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure — 9 hours

350x

DUE TO (b) Parkinsons Disease — 10-12 years

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from 24 Aug 1955 to 21 Oct 1956, that I last saw the deceased alive on 10-21 1956, and that death occurred at 2:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE G B Queen M.D.

ADDRESS (Street, city or town, state) 7112 Willow Ave Takoma Park Md

DATE SIGNED 22 Oct 56

PHYSICIAN'S NAME (Type) G B QUEEN

22a BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL

22b. DATE THEREOF 10/24/56

22c. NAME OF CEMETERY OR CREMATORY GRANDVIEW CEMETERY

22d. LOCATION (City, town, or county) (State) TYRONE, BLAIR COUNTY, PA.

23 FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey

ADDRESS SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE 10/23/56

24b REGISTRAR'S SIGNATURE Frances [illegible]

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10469

CERTIFICATE OF DEATH

10442

Reg. Dist. No 217

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burtonsville
c. LENGTH OF STAY IN 1b 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md
b. COUNTY Prince Geo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel
d. STREET ADDRESS
e. RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print) First M. Middle Capitola Last Hobbs

4 DATE OF DEATH Month October Day 25 Year 1956

5 SEX F

6 COLOR OR RACE W

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH May 22 1875

9 AGE (In years last birthday) 81 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk U.S. Gov.

10b KIND OF BUSINESS OR INDUSTRY US govt

11 BIRTHPLACE (State or foreign country)

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Daniel L. Hobbs

14 MOTHER'S MAIDEN NAME Margaret Doyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16 SOCIAL SECURITY NO ✓

17 INFORMANT Address Beulah Mayo Burtonsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH Minutes

DUE TO (b) Severe Coronary Atherosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Heart Disease

4001

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from June 1956 to October 1956 that I last saw the deceased alive on October 25 1956, and that death occurred at ____ P.M., from the causes and on the date stated above

ACTUAL SIGNATURE Robert C. Wingfield M.D. ADDRESS (Street, city or town, state) Laurel Md DATE SIGNED 10/27/56

PHYSICIAN'S NAME (Type) ROBERT C. WINGFIELD

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF 10/28/56

22c NAME OF CEMETERY OR CREMATORY St Marks Cem

22d LOCATION (City, town, or county) Highland (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Keith Donaldson ADDRESS Laurel Md.

24a. REC'D BY REGISTRAR DATE 10-30-56

24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician for completion. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10470

CERTIFICATE OF DEATH

Reg. Dist. No 2/7 10443

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 6 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montg. Co. Gen. Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.F.D. Monrovia
d. STREET ADDRESS: Holsey Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Horace; Middle: S.; Last: Holsey

4 DATE OF DEATH: Month: October; Day: 6; Year: 19 56

5 SEX: Male

6 COLOR OR RACE: Colored

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Jan. 17, 1872

9 AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Montg. Co., Md.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Holsey

14. MOTHER'S MAIDEN NAME: Catherine Potts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No
If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: None

17 INFORMANT: Mrs Emma F. Butler, Monrovia, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

DUE TO (b): Arteriosclerosis - generalized c Hypertension — ? years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): No injury

20c. TIME OF INJURY: Hour; a m / p m; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from October 6 19 56, to October 6 19 56, that I last saw the deceased alive on October 6, 19 56, and that death occurred at 3 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: M. McKendree Boyer M.D.

ADDRESS (Street, city or town, state): Druid Theatre Building, Damascus, Maryland.

DATE SIGNED: 10-7-56

PHYSICIAN'S NAME (Type): M. McKendree Boyer, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 9, 1956

22c. NAME OF CEMETERY OR CREMATORY: Friendship

22d. LOCATION (City, town or county) (State): Nr. Damascus, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ellis L. Molesworth

ADDRESS: Damascus, Md.

24a. REC'D BY REGISTRAR DATE: 10-10-56

24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10444

10471

CERTIFICATE OF DEATH

Reg Dist. No. 2/4

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: West Virginia — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland

c. LENGTH OF STAY IN 1b: 124 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Anawalt

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: - - - -

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Letha — Middle: Levine — Last: Holton

4. DATE OF DEATH: Month: October — Day: 21, — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 28, 1901

9. AGE (In years last birthday): 55 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Waitress Work

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Money

14. MOTHER'S MAIDEN NAME: Lena Dillard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 232-16-6375

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Metastatic Carcinoma of the Lung — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Anemia — 1 year

DUE TO

(c): Coma — 3 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour o. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 8, 1956 to October 21, 1956 that I last saw the deceased alive on October 21, 1956, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: David G. Nathan M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 10-22-56

PHYSICIAN'S NAME (Type): David G. Nathan, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-24-56

22c. NAME OF CEMETERY OR CREMATORY: MONTA VISTA

22d. LOCATION (City, town, or county) (State): BLUEFIELD, WEST VA

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co

ADDRESS: 1400 Chapin St

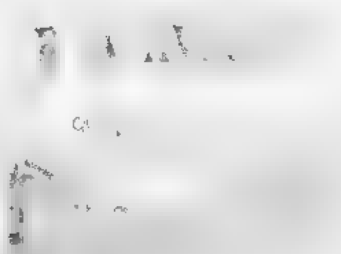
24a. REC'D BY REGISTRAR (Date): 10-24-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Hinchman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10472

CERTIFICATE OF DEATH

10445

Reg. Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Maryland

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Indiana
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marion
d. STREET ADDRESS: 112 S. Boots Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Mason — Last: HOSEA

4. DATE OF DEATH: Month: October — Day: 10 — Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 2, 1908

9. AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Drug Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Drug Co.

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert C. Hosea

14 MOTHER'S MAIDEN NAME: Blanche Hall

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: Unknown

17 INFORMANT: (Son) Robert Chambers Hosea — Address: (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): adenoma of pituitary — INTERVAL BETWEEN ONSET AND DEATH: 6 years

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 30 August, 19 56, to 10 October, 19 56, that I last saw the deceased alive on 10 October, 19 56, and that death occurred at 2:40 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. H. Drickemiller M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 10-11-56

PHYSICIAN'S NAME (Type): W.H. DRICKEMILLER, CAPT.MC,USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-15-56

22c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery

22d LOCATION (City, town or county) (State): Marion, Indiana

23. FUNERAL DIRECTOR'S SIGNATURE: Robert Kingsley — ADDRESS: Bethesda, Md. — 23a. Purnell F. Purnell Funeral Home, 7557 Wisconsin Ave.

24a. REC'D BY REGISTRAR DATE: 10-11-56

24b. REGISTRAR'S SIGNATURE: Mary E. Connelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event with in 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10446

10473

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3001 Ferndale St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First PATRICK Middle Howard Last
4. DATE OF DEATH: Month 10 — Day 11 — Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12 - 15 - 65
9. AGE (In years last birthday): 91 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Ice Mfg. - Foreman
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Howard
14. MOTHER'S MAIDEN NAME: Ann Lynn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 204-20-6380 A
17. INFORMANT: Mrs. Mary Boone - Niece — Address: 3001 Ferndale St. Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

DUE TO (b): Intestinal Obstruction — 10 days

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma, Sigmoid

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.: ~~Oct 10~~ Oct 11 1956
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 5, 1956 to Oct 11, 1956 that I last saw the deceased alive on Oct 10, 1956, and that death occurred at 2:50 A. M. from the causes and on the date stated above

ACTUAL SIGNATURE: John P. Haberlin M.D. — ADDRESS (Street, city or town, state): 918 Ellsworth Drive, Silver Spring Md — DATE SIGNED

PHYSICIAN'S NAME (Type): JOHN P. HABERLIN

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. FOR BURIAL
22b. DATE THEREOF: 10/15/56
22c. NAME OF CEMETERY OR CREMATORY: ST. MARK'S CEMETERY
22d. LOCATION (City, town, or county) (State): BRISTOL, BUCKS COUNTY, PA.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 10-15-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10474

CERTIFICATE OF DEATH

10447

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hosp

7 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 906 Wade Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pauline — Middle: Mary — Last: Hunt
4. DATE OF DEATH: Month: 10 — Day: 21 — Year: 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-14-94
9. AGE (in years last birthday): 62 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Deaf
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maine
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward Leonard
14. MOTHER'S MAIDEN NAME: Mary Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Joseph Hunt — Husband — Address: [illegible] Rockville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pleural Effusion, Bil. (150000) — Interval between onset and death: 1 week
DUE TO (b): Hypertensive Heart Disease + Cardiomegaly — 3 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-20-53 to 10-21-56, that I last saw the deceased alive on 10-21-56, and that death occurred at 8:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen N. Jones M.D.
ADDRESS (Street, city or town, state): Rockville Md
DATE SIGNED: 10/21/56

PHYSICIAN'S NAME (Type): Stephen N. Jones, M. D. — Rockville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 23 1956
22c. NAME OF CEMETERY OR CREMATORY: Lakewood Cem
22d. LOCATION (City, town or county): Hamilton (State): Va

23. FUNERAL DIRECTOR'S SIGNATURE: Robert C. Humphrey
ADDRESS: Bethesda Md 7517 Woodmont Ave
24a. REC'D BY REGISTRAR — DATE: 10-24-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Stevenson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

10448

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

104[illegible]2

CERTIFICATE OF DEATH

Reg. Dist. No. 223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death [illegible] the funeral director, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible]
c. LENGTH OF STAY IN 1b: [illegible]
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7501 Flower Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) — First: — Middle: — Last: [illegible]

4. DATE OF DEATH — Month: October — Day: 2 — Year: 1956

5. SEX: [illegible]
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 2, 56
9. AGE (In years last birthday): — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min 47

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: [illegible]
14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: —
17. INFORMANT: [illegible] — Address: 7501 Flower Av[illegible] Takoma Park [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Prematurity (gestation age 28 weeks by measurement)
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Incomplete expansion of lungs
DUE TO
(c) aspiration vernix caseosa (formation of pulmonary hyaline membrane)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 — Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-2-56, 19___, to 10-2-56, 19___, that I last saw the deceased alive on 10-2-56, 19___, and that death occurred at 9:40 p.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Ruth Standard M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED 10-21-56

PHYSICIAN'S NAME (Type): Ruth Standard, M.D. Washington Sanitarium and Hospital, Takoma Park, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 10-21-56
22c. NAME OF CEMETERY OR CREMATORY: Wash. San. & Hospital
22d. LOCATION (City, town, or county): Takoma Park — (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible], MD. — ADDRESS: Washington San & Hospital Takoma Park, Md.
24a. REC'D BY REGISTRAR DATE: 10/[illegible]/56
24b. REGISTRAR'S SIGNATURE: [illegible]

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10449

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND — 10475
b. CITY OR TOWN (Outside corporate limits, write RURAL and give nearest town): Bethesda, Md.
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bethesda Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) — a. STATE: Bethesda, Md. — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS: 5022 Alta Vista Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Hilda — Middle Leigh — Last Jackson

4. DATE OF DEATH: Month 10 — Day 31 — Year 1956

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-22-02
9. AGE (In years last birthday): 54 yrs
IF UNDER 1 YEAR: Months 1 — Days 9
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Arthur [redacted] Holmes
14. MOTHER'S MAIDEN NAME: Margaret Sewell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Husband — Address: Dr. Fritz R. Jackson, 5022 Alta Vista Rd Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Myocardial [illegible], [illegible] Ventricular
DUE TO (b): Coronary thrombosis, Cirrhosis
DUE TO (c): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 29, 1956, to Oct. 31, 1956, that I last saw the deceased alive on Oct. 31, 1956, and that death occurred at 11:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles J. Savarese Jr. M.D. — ADDRESS (Street, city or town, state): 4801 Battery Lane, Bethesda, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): Charles J. Savarese, Jr. — 4801 Battery Lane, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11-2-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Albert R. Murphrey — ADDRESS: Bethesda, Md.
24a. RECD BY REGISTRAR DATE: 11-2-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10450 VVS

10413

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 35 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 115 Lincoln Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 115 Lincoln Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Jordon
4. DATE OF DEATH: Month: 10/9/56 — Day — Year: 19

5. SEX: male
6. COLOR OR RACE: col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/31/88
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Miss.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Phillip Jordon
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lee A. Jordan — Address: 28 Ritchie Ave., Silver Springs, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank J. Broschart
DATE SIGNED: 10/11/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/13/56
22c. NAME OF CEMETERY OR CREMATORY: Ash Memprial Cemetery
22d. LOCATION (City, town, or county) (State): Sandy Spring, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
24a. RECD. BY REGISTRAR DATE:
24b. REGISTRAR'S SIGNATURE: Nelson Dodd

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

10451

10476

CERTIFICATE OF DEATH

Reg Dist. No. 276

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Md.

c. LENGTH OF STAY IN 1b: 24 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 1821 P Street, S. E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lula — Middle: Mae — Last: Joyner

4. DATE OF DEATH: Month: October — Day: 12, — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ W DOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: November 22, 1888

9. AGE (In years last birthday): 67 yrs

If UNDER 1 YEAR: Months / Days — If UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Florida

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Ramsey

14. MOTHER'S MAIDEN NAME: Mary J. Letchworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Myelocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from September 18 19 56, to October 12, 19 56, that I last saw the deceased alive on October 12, 1956, and that death occurred at 7:12 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard R. Engel M.D.

PHYSICIAN'S NAME (Type): Howard R. Engel, M. D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 10/12/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: Oct 12, 1956

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): ALEXANDRIA VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: J. S. Ellis — ADDRESS: 809 King St. ALEXANDRIA VA.

24a. REC'D BY REGISTRAR DATE: 1-17 56

24b. REGISTRAR'S SIGNATURE: Bessie M. Hoover

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10477

CERTIFICATE OF DEATH

10452

Reg. Dist No. 2-16

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda — c. LENGTH OF STAY IN 1b: 20 min.
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 5911 Le May Rd. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Edith — Middle: — Last: Kephart
4 DATE OF DEATH: Month: Oct. — Day: 28 — Year: 1956

5 SEX: Female — 6. COLOR OR RACE: White — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8 DATE OF BIRTH: July 2 1879 — 9 AGE (In years last birthday): 77 yrs — IF UNDER 1 YEAR: Months: 3, Days: 26 — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired teacher. — 10b. KIND OF BUSINESS OR INDUSTRY: Teacher — 11 BIRTHPLACE (State or foreign country): Virginia — 12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Samuel Milton Luther — 14 MOTHER'S MAIDEN NAME: Ellen Bane

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No — — 16. SOCIAL SECURITY NO: None — 17 INFORMANT: Mrs. A. Rougrod — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchopneumonia, L.L. Bil —
DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): & Rheumatic Heart Disease and
DUE TO
(c): Mitral Valvulitis & Cor pulmonale

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Cholecystitis & cholelithiasis — 19 WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-8 Oct. 1956 to 2-5 Oct. 1956, that I last saw the deceased alive on 2-8 Oct. 1956, and that death occurred at 12:45 AM, from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Suburban Hospital — DATE SIGNED

PHYSICIAN'S NAME (Type): J. E. Ash — Bethesda 14, Md. — 29 Oct 56

22a BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 10/31/1956 — 22c NAME OF CEMETERY OR CREMATORY: Union — 22d LOCATION (City, town, or county) (State): Leesburg Virginia

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Beth. Md. — 24a REC'D BY REGISTRAR DATE: 10-31-56 — 24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10478 10453

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8031 EASTERN AVENUE

2 USUAL RESIDENCE (Where deceased lived. If not in institution, Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d. STREET ADDRESS 8031 EASTERN AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First PHILIP Middle B. Last KEY
4 DATE OF DEATH: Month OCTOBER Day 25 Year 1956

5 SEX MALE
6 COLOR OR RACE WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH 7/25/88
9 AGE (In years last birthday) 68 yrs
IF UNDER 1 YEAR, IF UNDER 24 HRS: Months Days Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE (own business)
10b KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) FREDERICK, MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILLIAM T. KEY
14. MOTHER'S MAIDEN NAME JOSEPHINE BALTZELL

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16 SOCIAL SECURITY NO 578-09-3631
17 INFORMANT Address Mr. Philip B. Key, Jr., #3 Pooks Hill Rd. Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma. — INTERVAL BETWEEN ONSET AND DEATH: 6 hours.
DUE TO
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) Carcinoma of bladder with — 1 month.
DUE TO
(c) liver metastases

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchitis, acute.
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 1954 to October 1956 that I last saw the deceased alive on 25 Oct. 1956, and that death occurred at 11:15 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Seruch T. Kimble M.D. ADDRESS (Street, city or town, state) 922 Pershing Drive, Silver Spring, Md. DATE SIGNED
PHYSICIAN'S NAME (Type) SERUCH T. KIMBLE

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 10/29/56
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY
22d LOCATION (City, town, or county) (State) WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey ADDRESS SILVER SPRING, MD.
24a REC'D BY REGISTRAR DATE 9/29/56
24b REGISTRAR'S SIGNATURE Francis Fetter

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled out by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event with in 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10454

10479

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 16-5-6-10-4-56

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brom Md
d. STREET ADDRESS: 720 Hunts Point Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Kensington Gardens San

3. NAME OF DECEASED (Type or print): First: Malvina (Koenig) Middle: King Last: King
4. DATE OF DEATH: Month: 10 Day: 4 Year: 1956
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 15 1871
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Budapest Hungary
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Bernard Hochdorf
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Albert King Address: 720 Hunts Point Ave

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH
420.0
DUE TO (b): Arteriosclerotic heart disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
Hypertension

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/24, 1956, to 10/4, 1956, that I last saw the deceased alive on 10/4, 1956, and that death occurred at 11:45 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Charles M Weber M.D. ADDRESS (Street, city or town, state): Wheaton City Md DATE SIGNED: Oct 4 1956
PHYSICIAN'S NAME (Type): Charles M Weber

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 5 1956
22c. NAME OF CEMETERY OR CREMATORY: King Solomon Cem
22d. LOCATION (City, town or county) (State): Clifton N J

23. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home ADDRESS: 4812 Georgia Ave Wheaton
24a. REC'D BY REGISTRAR DATE: 10/4/56
24b. REGISTRAR'S SIGNATURE: Frances Tittes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be re[illegible] by the hospital or attending physic an.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10455

CERTIFICATE OF DEATH

10480

Reg. Dist No. 24

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 10707 St. Marguerite Way

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10707 St. Marguerite Way
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Felix; Middle:; Last: Klaber

4. DATE OF DEATH: Month: Oct. Day: 15 Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 21, 1887

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Food Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Klaber

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Caroline Hirsch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Address: Nephew
Harry Bodansky, 10707 St. Marguerite Way

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion, Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 13, 1956, to Oct 15, 1956, that I last saw the deceased alive on Oct 15, 1956, and that death occurred at 6:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John J. Curry M.D. ADDRESS (Street, city or town, state): 11301 Georgia Ave. Silver Spring Md. DATE SIGNED: 10/15/56

PHYSICIAN'S NAME (Type): John J. Curry

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/18/56

22c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah

22d. LOCATION (City, town, or county) (State): New ~~York~~ Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: B. Bonsanby & Son, ADDRESS: 3501 14th St. N.W.

24a. REC'D BY REGISTRAR DATE: 10/24/56

24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10456

10481

CERTIFICATE OF DEATH

Reg. Dist No. 21-4

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 831 GIST AVENUE

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 831 GIST AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First MARY SUE Middle PARKER Last LEISSLER

4 DATE OF DEATH: Month OCTOBER Day 7 Year 1956

5 SEX: FEMALE
6. COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: OCT. 16, 1893
9 AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): SHIPPING CLERK (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: ENGRAVING
11 BIRTHPLACE (State or foreign country): WASHINGTON, D. C.
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM A. PARKER
14. MOTHER'S MAIDEN NAME: MATTIE HAMILTON

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: 578-01-4917
17 INFORMANT Address: MRS. ANNA M. BRADY, 831 GIST AVE., SILVER SPRING

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): MITRAL INSUFFICIENCY — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs
DUE TO (b): [illegible] — [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): [illegible] — [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above

ACTUAL SIGNATURE: [illegible] M.D.
ADDRESS (Street, city or town, state): 9013 FLOWER AVE SILVER SPRING MD
DATE SIGNED: [illegible]
PHYSICIAN'S NAME (Type): L. B. SNOW

22a BURIAL CREMATION REMOVAL (Specify): BURIAL
22b DATE THEREOF: OCT. 11, 1956
22c NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY
22d LOCATION (City, town, or county) (State): WASHINGTON, D. C.

23 FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey
ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 10/9/56
24b REGISTRAR'S SIGNATURE: Frances [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be related by the hospital or attending physician on
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial transit permit. Then please arrange carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10482

10457

CERTIFICATE OF DEATH

Reg. Dist. No 214

1 PLACE OF DEATH
a. COUNTY: Montgomery County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 7 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 700 Forest Glen Road

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 700 Forest Glen Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Hiram; Middle: ; Last: Lewis

4 DATE OF DEATH: Month: October; Day: 29; Year: 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 4, 1878
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Self Emp.
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Andrew J. Lewis
14. MOTHER'S MAIDEN NAME: Frances A. Mozingo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Ada Lewis-Wife
Address: Mrs. Orville S. Kennedy-700 Forest Glen Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cancer of Colon (Transverse, Colon)
INTERVAL BETWEEN ONSET AND DEATH: 3 years
155X
DUE TO
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 19 56 to Oct 29, 19 56, that I last saw the deceased alive on Oct 29, 19 56, and that death occurred at 7 a.m. M, from the causes and on the date stated above

ACTUAL SIGNATURE: John N. Andrews M.D.
ADDRESS (Street, city or town, state): 9601 Colesville Road
DATE SIGNED:

PHYSICIAN'S NAME (Type): Dr. John N. Andrews, M.D. 9601 Colesville Road S.S., Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/29/56
22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
22d. LOCATION (City, town, or county) (State): Rainswood, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: James T. Ryan, Jr.
ADDRESS: James T. Ryan, Inc. 317 Pa. Ave., SE DC3

24a. REC'D BY REGISTRAR DATE: 2, 1956

24b. REGISTRAR'S SIGNATURE: Frances Potter

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10458

10483 **CERTIFICATE OF DEATH** Reg. Dist. No. 216

VS. A15 — 10 -

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Montgomery MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4703 W.Virginia Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
STREET ADDRESS (If rural give location) 4703 W. Virginia Avenue

3. NAME OF DECEASED (Type or Print) (First) Rudolf (Middle) (Last) Lieberts

4. DATE OF DEATH (Month) Oct. (Day) 26 (Year) 1956

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Feb.10,1876
9. AGE last birthday 80 yrs IF UNDER 1 YEAR Months 8 Days 16 IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Fruits & Wholesaler- Veg.
10B. KIND OF BUSINESS OR INDUSTRY Wholesaler
11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Lieberts
14. MOTHER'S MAIDEN NAME Caroline Wallerstein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) --
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT & ADDRESS Daughter-Miss Hermine Lieberts-Item 2

18. MEDICAL CERTIFICATION

			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE	(A)	Carcinoma of Stomach	6 months
ANTECEDENT CAUSE (S)	DUE TO (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			

19A. DATE OF OPERATION: Aug 1, 1956
19B. MAJOR FINDINGS OF OPERATION [illegible] carcinomatosis
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1956 to Oct 26, 1956, that I last saw the deceased alive on Oct 25, 1956, and that death occurred at 6 A M, from the causes and on the date stated above.

SIGNATURE [illegible] M D ADDRESS [illegible] DATE SIGNED [illegible]

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation
DATE THEREOF 10/26/56
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) Suitland (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 10-27-56
REGISTRAR'S SIGNATURE Bessie M Thompson
24. FUNERAL DIRECTOR Robert A. Pumphrey
ADDRESS Bethesda,Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10459

CERTIFICATE OF DEATH

10484 Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 6 Mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3604 Little Dale Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3604 Little Dale Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: MARGARET — Middle: OLIVIA — Last: LILLEY

4 DATE OF DEATH: Month: October — Day: 13, — Year: 1956

5 SEX: Female — 6 COLOR OR RACE: White — 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Mar. 4, 1888 — 9 AGE (In years last birthday): 68 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: None — 11 BIRTHPLACE (State or foreign country): Plymouth, N. C. — 12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Taylor Walker Davis — 14. MOTHER'S MAIDEN NAME: Lillian Ayers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No. — 16. SOCIAL SECURITY NO.: None — 17 INFORMANT: Son, Harold R. Lilley — Address: 3604 Little Dale Rd. Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

DUE TO (b): Diffuse Vasculitis — 6 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOT, BY MEDICAL EXAMINER) — 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21 I certify that I attended the deceased from March, 1953 to Oct 13, 1956 that I last saw the deceased alive on Oct 13, 1956, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James J. Feffer, M.D. — ADDRESS (Street, city or town, state): 1711 R. I. Ave N.W. — DATE SIGNED

PHYSICIAN'S NAME (Type): James J. Feffer — Wash 6, D.C.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit — 22b. DATE THEREOF: 10-14-56 — 22c NAME OF CEMETERY OR CREMATORY: Windley Cemetery — 22d LOCATION (City, town, or county) (State): Washington County, N. C.

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md. — 24a REC'D BY REGISTRAR DATE: 10-15 — 24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10455

10460

CERTIFICATE OF DEATH

Reg Dist. No. 2.16

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 26 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Maryland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Moreland Hills
d. STREET ADDRESS 5004 Worthington Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Eloise Middle K Last Linkins

4. DATE OF DEATH Month 10 Day 14 Year 1956

5 SEX Female
6 COLOR OR RACE White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 9-21-80
9 AGE (In years last birthday) 76 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11 BIRTHPLACE (State or foreign country) Washington, D.C.,
12 CITIZEN OF WHAT COUNTRY? U.S.A.,

13. FATHER'S NAME J. Henry Kaiser
14 MOTHER'S MAIDEN NAME Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17 INFORMANT William J. Biggins, Jr. Address 3925 W St. N.W. Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma, Metastatic from Common Bile duct
INTERVAL BETWEEN ONSET AND DEATH ?
157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Adenocarcinoma, Pancreas -
DUE TO (c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from Aug 15, 1956, to Oct 15, 1956, that I last saw the deceased alive on 10-14, 1956, and that death occurred at 2:55 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE Howard H. Strine M.D. ADDRESS (Street, city or town, state) 900-17th St. N.W. Wash. D.C. DATE SIGNED
PHYSICIAN'S NAME (Type) Howard H. Strine

22a BURIAL, CREMATION, REMOVAL (Specify) burial
22b. DATE THEREOF 10/16/56
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
22d LOCATION (City, town, or county) (State) Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The S.H. Hines Company, 2901 11th St. N.W. Washington, D.C.
24a REC'D BY REGISTRAR 10-17-56
24b REGISTRAR'S SIGNATURE Bernice Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

YS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10461

.10486 **CERTIFICATE OF DEATH**

Reg. Dist No 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Mar Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 5204 Nahant Street

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Mar Park
d. STREET ADDRESS: 5204 Nahant Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Martin — Middle — Last LUCAS

4 DATE OF DEATH: Month October — Day 5 — Year 19 56

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: May 12, 1905
9 AGE (In years at birthday): 51 yrs
IF UNDER 1 YEAR: Months 4 Days 23 — IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Electrical Inspector
10b. KIND OF BUSINESS OR INDUSTRY: State of Virginia
11 BIRTHPLACE (State or foreign country): Czecho-Slovakia
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Lucak
14 MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, No, or unknown): Yes
(If yes, give war or dates of service): Korean
16. SOCIAL SECURITY NO: 204-34-1958
17 INFORMANT — Address: Mary E. Lucas-Same Item #2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Amyotrophic Latiral Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 11 m.o.
356.1
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dead on arrival - medical examiner notified
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from October 5, 1956 to October 5, 1956 that I last saw the deceased alive on October 5, 1956, and that death occurred at 7:15 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
ACTUAL SIGNATURE Virginia P. Beelar M.D.
PHYSICIAN'S NAME (Type) Virginia P. Beelar, M.D. 5715 Massachusetts Ave. Glen Mar Pk. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-9-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d LOCATION City, town, or county: Arlington (State): Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.
24a. REC'D BY REGISTRAR (Date): 10-8-56
24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be related by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial or transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) TSM 9/55

Mr. Brochart notified and approved removal

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10462

10487

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C. b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9913 Tenbrook Drive

d. STREET ADDRESS: 1868 Columbia Road, N.W. Apt 505

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Sussie Middle: Gertrude Last: Mangum

4 DATE OF DEATH: Month, Day, Year: 10/22/56 19

5. SEX: female 6. COLOR OR RACE: white 7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 8/8/1903

9 AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months, Days IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Baltimore, Md.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Arthur B. Allen

14. MOTHER'S MAIDEN NAME: Nettie Viola Leonard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16 SOCIAL SECURITY NO:

17 INFORMANT: Clarence S. Allen, Address: Ashton, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO (b): Coronary artery occlusion

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — DUE TO (c):

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from April, 1956, to Oct 22, 1956, that I last saw the deceased alive on October 22, 1956, and that death occurred at 4:40 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Morris H Rosenberg M.D. ADDRESS (Street, city or town, state): 2025 Eye St NW DATE SIGNED:

PHYSICIAN'S NAME (Type): MORRIS H. ROSENBERG

22a BURIAL, CREMATION, REMOVAL (If specify):

22b. DATE THEREOF: 10/25/56

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

22d LOCATION (City town or county) (State): Baltimore, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Co., ADDRESS: Wash, D.C. 2901 14th St. N.W.

24c REC'D BY REGISTRAR DATE: 10/24/56

24b REGISTRAR'S SIGNATURE: Frances Tolley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician or TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the Funeral director page 3 should be detached for use as the burial transit permit. Then pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9-55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10488

CERTIFICATE OF DEATH

10463

Reg. Dist. No. 217

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County Gneral Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Maryland
b COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Martha — Middle Selberta — Last Marsell

4. DATE OF DEATH: Month October — Day 20 — Year 19 56

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/22/90
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henson Taylor
14. MOTHER'S MAIDEN NAME: Tony Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Record (Daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cardiac Failure.
DUE TO (b): Cerebral Vascular Accident (Cerebral Hemorrhage)
DUE TO (c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/19, 19 56, to 10/20, 19 56 that I last saw the deceased alive on 10/20, 19 56, and that death occurred at 11:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lewis J. Leal M.D. ADDRESS (Street, city or town, state): 108 N. Frederick Ave. Gaithersburg Md. DATE SIGNED:

PHYSICIAN'S NAME (Type): L. J. Leal, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/23/56
22c. NAME OF CEMETERY OR CREMATORY: Emory Grove,
22d. LOCATION (City, town, or county) (State): Emory Grove, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert F. Snowden
ADDRESS: Rockville, Md
24a. REC'D BY REGISTRAR DATE: 10-24-56
24b. REGISTRAR'S SIGNATURE: Gertrude B Lawler

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10414

CERTIFICATE OF DEATH

10464
Reg. Dist. No. 223

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Washington San + Hosp Takoma Park Md

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Washington DC
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: 1349 A st. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Dorothea — Last: Matthaei

4. DATE OF DEATH: Month: October — Day: 24 — Year: 1956

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 20, 1885

9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Henry Russel

14. MOTHER'S MAIDEN NAME: Julia Schmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: Address: Wash. San + Hosp. Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO (b): Beta Stalic Carcinoma — 1 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Carcinoma of Uterus or ovary — 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. / Month / Day / Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 7, 19 56 to Oct 24, 19 56 that I last saw the deceased alive on Oct 24, 19 56, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Raymond O. West M.D. — ADDRESS (Street, city or town, state): 7600 Carroll ave. T. Park Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Dr. Raymond O. West, M. D. 7600 Carroll Ave., Takoma Park, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Oct. 27, 1956 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill — 22d. LOCATION (City, town, or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Pellington Sons Co — ADDRESS: 300 4th St. N.W.

24a. RECEIVED BY REGISTRAR DATE: 10/27/56 — 24b. REGISTRAR'S SIGNATURE: J. Hilton Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician on request. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10415

CERTIFICATE OF DEATH

Reg. Dist No. 10465

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 13 days

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington DC.
d. STREET ADDRESS: 2726 30th Street NE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

3 NAME OF DECEASED (Type or print): First: Anna — Middle: Kathrine — Last: McCalment

4 DATE OF DEATH: Month: Oct — Day: 4 — Year: 1956

5. SEX: Female
6. COLOR OR RACE: Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 12, 1874
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: William Schaaf
14. MOTHER'S MAIDEN NAME: Anna Billingsley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mr. Gerald C. McCalment - Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma of Gall bladder with metastasis — INTERVAL BETWEEN ONSET AND DEATH: about 6 months
155X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a.m. p.m. Month: Day: Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 19 56 to October 4 19 56, that I last saw the deceased alive on October 3, 19 56, and that death occurred at 5:30 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: Jack J. Rheingold M.D.
ADDRESS (Street, city or town, state): 1307 18th St. NW.
DATE SIGNED: 10/4/56
PHYSICIAN'S NAME (Type): JACK J. RHEINGOLD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/8/56
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Nalley Funeral Home 3200 R.I. Ave
mt. RAINIER MD.

24a. REC'D BY REGISTRAR DATE: OCT
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filed, the funeral director page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10489 10466

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH
a COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c LENGTH OF STAY IN 1b: 12 yrs.
d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 805 KING STREET

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND — b COUNTY: MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 805 KING STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First WILLIAM — Middle A. — Last McCOLLAM

4 DATE OF DEATH: Month OCTOBER — Day 11 — Year 19 56

5 SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: APRIL 30, 1884

9. AGE (In years last birthday): 72 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): BRICKLAYER

10b. KIND OF BUSINESS OR INDUSTRY: CONTRACTORS

11 BIRTHPLACE (State or foreign country): BLADENSBURG, MARYLAND

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD F. McCOLLAM

14. MOTHER'S MAIDEN NAME: EMMA CHANEY

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): NO
If yes, give war or dates of service:

16 SOCIAL SECURITY NO: 578-01-9184

17 INFORMANT: Mrs. Mary B. Carr — Address: 805 King St., Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CARCINOMA (HEPATOMA) — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): DUODENAL ULCER

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1955 19__ to 11 Oct 19 56 that I last saw the deceased alive on 11 Oct 19 56, and that death occurred at 3 1 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.

ADDRESS (Street, city or town, state): 9013 FLOWER AV SILVER SPRING, MD

DATE SIGNED: 11/16/56

PHYSICIAN'S NAME (Type): L. B. SNOW

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 10/15/56

22c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEMETERY

22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Wakney E. Dunphrey — ADDRESS: SILVER SPRING, MD.

24a. RECEIVED BY REGISTRAR DATE: 10/1/56

24b REGISTRAR'S SIGNATURE: Francis Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death Page 4 may be re[illegible] by the hospital or attending physician
TO FUNERAL DIRECTOR: After this cert ficate has been signed by the attend ng physician and completely filled [illegible] the funeral director, page 3 sh[illegible]uld be detached for use as the burial transit permit Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

YS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10490

10467

CERTIFICATE OF DEATH

Reg Dist No 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4½ hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Virginia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annandale
d. STREET ADDRESS: 5013 Bristow Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby Middle: Boy Last: MC DONOUGH

4. DATE OF DEATH: Month: Oct. Day: 19 Year: 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 19 Oct. 1956

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS: Hours 4 | Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert C. Mc Donough

14. MOTHER'S MAIDEN NAME: Juliette Marie Schonekas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - -

16. SOCIAL SECURITY NO: None

17. INFORMANT: Father) Robert C. Mc Donough (Same As #2)
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c): Fetal atelectasis — 4 Yzhrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 Oct. 19 56 to 19 Oct. 19 56 that I last saw the deceased alive on 19 Oct. 19 56, and that death occurred at 1:05 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: John H. Mazur M.D. ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. DATE SIGNED: 10-20-56

PHYSICIAN'S NAME (Type): John H. Mazur, LT MC USN — U.S. Naval Hosital, Bethesda, Md. 10-20-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 23 Oct. 1956

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

22d. LOCATION (City, town or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: Bethesda, Md.
R.A. Purdy Funeral Home, 7557 Wisconsin Ave.,

24a. REC'D BY REGISTRAR DATE: 10-20-56

24b. REGISTRAR'S SIGNATURE: Mary E. Connelly

2051956 XVS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10416 10468

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1 PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE D.C. b COUNTY

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington

d. STREET ADDRESS 627 Georgia Ave NW

e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Annette Middle — Last Mendelsohn

4 DATE OF DEATH Month October Day 11 Year 1956

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH 2-18-98

9 AGE (In years last birthday) 58 yrs

IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home duties

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) Md.

12 CITIZEN OF WHAT COUNTRY? America

13 FATHER'S NAME [illegible] Walckey

14 MOTHER'S MAIDEN NAME Esther Sipp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 577-44-9503

17 INFORMANT Chart Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Hypertensive Arteriosclerotic — many years

DUE TO (c) Cardiac vascular Disease — about 10 years

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that I attended the deceased from 10/6, 1956, to 10/11, 1956, that I last saw the deceased alive on 10/11, 1956, and that death occurred at 6:30 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE Benjamin Isaacson M.D. ADDRESS (Street, city or town, state) 7733 Alaska Ave NW Washington, D.C. DATE SIGNED 10/11/56

PHYSICIAN'S NAME (Type) BENJAMIN ISAACSON

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 10-14-1956

22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship

22d. LOCATION (City, town, or county) (State) Baltimore, Md

23 FUNERAL DIRECTOR'S SIGNATURE Danzansky Goldberg Funeral Home ADDRESS 4217-9th St. n.w. Wash. D.C.

24a. REC'D BY REGISTRAR DATE 10/15/56

24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL—ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death and may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

I

VS AIS (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10469

10491

CERTIFICATE OF DEATH

Reg. Dist. No. —

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 11 YEARS
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 8808 READING ROAD

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: M D.
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 8808 READING ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ALEXANDRA Middle — Last MILKIE

4 DATE OF DEATH: Month OCTOBER Day 31 Year 1956

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: FEB ? 1866
9. AGE in years (last birthday): 90 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): LEBANON
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ABRAHAM MAFRIGE
14. MOTHER'S MAIDEN NAME: KATHERINE JEHA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No / NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mr Michael Milkie-Son — Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congestive Heart Failure, Acute — INTERVAL BETWEEN ONSET AND DEATH: 2 days
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Hemorrhage with Hemiplegia — 2 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 19 54 to Oct 31 19 56, that I last saw the deceased alive on Oct 31 19 56, and that death occurred at 1030 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L B Snow M.D.
ADDRESS (Street, city or town, state): 9613 Silver Spring, Md.
DATE SIGNED: 11/1/56
PHYSICIAN'S NAME (Type): L. B. SNOW

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/3/56
22c. NAME OF CEMETERY OR CREMATORY: Glenwood
22d. LOCATION (City, town, or county) (State): Washington dc

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: Riverdale, Md.
24a. REC'D BY REGISTRAR DATE: 11/1/56
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10470

10492

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5803 Johnson Court

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5803 Johnson Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Wilson — Middle: Noble — Last: MILLER

4 DATE OF DEATH: Month: October — Day: 10 — Year: 19 56

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 23, 1880
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months: 11 — Days: 17
IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Plate printer
10b. KIND OF BUSINESS OR INDUSTRY: Bureau of Engrav.
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wilson Porter Miller
14. MOTHER'S MAIDEN NAME: Mary F. Darby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT — Address: Mrs. Frances Daly-Same Item #2-daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis General — yrs
DUE TO
(c):

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APR. 19 52 to Oct 10, 19 56 that I last saw the deceased alive on Oct 10, 19 56, and that death occurred at 9:10 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Leo M. Curtis M.D. — ADDRESS (Street, city or town, state): 8218 Wisconsin Ave Bethesda Md — DATE SIGNED: 10/10/56

PHYSICIAN'S NAME (Type): Leo M. Curtis, M.D. — 8218 Wisconsin Ave. Bethesda, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/12/1956
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county) (State): Prince Georges Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Puniphrey-7557Wis. Ave. Bethesda, Md
24a. REC'D BY REGISTRAR — DATE: 10-11-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10471

10493

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland

c. LENGTH OF STAY IN 1b: 41 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 7 Ardmore Court

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Charles — Middle: Carroll — Last: Morgan, Jr.

4 DATE OF DEATH: Month: October — Day: 23, — Year: 1956

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: August 22, 1923

9 AGE (In years last birthday): 33 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Banker

10b KIND OF BUSINESS OR INDUSTRY: Security & Trusts

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Charles C. Morgan, Sr.

14 MOTHER'S MAIDEN NAME: Adalaide L. Tuttle

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes — WW II

16. SOCIAL SECURITY NO: 577-40-4922

17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): malignant melanoma

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): diffusely metastatic

DUE TO

(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from August 28, 1956, to October 23, 1956, that I last saw the deceased alive on October 23, 1956, and that death occurred at 12:42 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: David G. Nathan M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 10/23/56

PHYSICIAN'S NAME (Type): David G. Nathan, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 10/25/56

22c NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d LOCATION (City, town, or county) (State): Washington D.C.

23 FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons

ADDRESS: 1756 Pennsylvania Ave NW Washington, D.C.

24a REC'D BY REGISTRAR DATE: 10-25-56

24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10472

Reg. Dist No. 223

10417

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 14 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium Hospital

2 USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 7710 Alaska Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Cora Middle Thomas Last Morris
4. DATE OF DEATH: Month October Day 27 Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 4-3-1876
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME John Thomas Morris
14. MOTHER'S MAIDEN NAME Maud [illegible] HOBGOOD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ————
16. SOCIAL SECURITY NO. ————
17. INFORMANT Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
430.0
DUE TO (b) Cerebral laceration — 2 weeks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Fell down basement steps at home
20c. TIME OF INJURY: Hour 2 p. m. Month, Day, Year 10/13 1956
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Silver Spring (County) Mont. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Frank J. Broschart M.D.
EXAMINER'S NAME (Type) Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 10/28/56

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/29/56
22c. NAME OF CEMETERY OR CREMATORY WENDELL CEMETERY
22d. LOCATION (City, town, or county) (State) WENDELL, N.C.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS W. J. Hefner & Son Baltimore, Md.
24c. REC'D BY REGISTRAR DATE OCT 29 1956
24b. REGISTRAR'S SIGNATURE Thomson Todd

1

DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be detached for your files. Pages 1 and 2 with the registrar prior to burial, cremation or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.

2

VS A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10491 10473

CERTIFICATE OF DEATH

Reg. Dist. No. 2-4

1 PLACE OF DEATH a COUNTY Montgomery MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND
LENGTH OF STAY IN 16 Sept. 30, 1956
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fairland Nursing Home

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE MARYLAND b COUNTY MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d STREET ADDRESS 1711 MAYHEW DRIVE
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First Elma Middle JANE Last Moss
4 DATE OF DEATH Month OCTOBER Day 6 Year 19 56

5 SEX F
6 COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8 DATE OF BIRTH JUNE 25, 1880
9 AGE (Last birthday) 76 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOMEMAKER
10b KIND OF BUSINESS OR INDUSTRY OWN HOME
11 BIRTHPLACE (State or foreign country) PENNSYLVANIA
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME GEORGE RAKER
14 MOTHER'S MAIDEN NAME SARAH ELIZABETH McVOY

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO NONE
17 INFORMANT Address Mr. Wm. Andrew Fagan, 4303 Elderon Ave. Baltimore, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage — Interval between onset and death: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Art. Sclerosis — 8 yrs
DUE TO (c) Arteriosclerosis — 15 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonitis - one day
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 1953 19 55 to 6 Oct 19 56 that I last saw the deceased alive on 6 Oct 19 56, and that death occurred at 4 P M, from the causes and on the date stated above

ACTUAL SIGNATURE Merton L. White M.D. ADDRESS (Street, city or town, state) 11134 Georgia Ave Silver Spring DATE SIGNED 10/6/56

PHYSICIAN'S NAME (Type) Merton L. White

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Oct. 9, 1956
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery
22d LOCATION (City, town, or county) (State) Montgomery County, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey ADDRESS Silver Spring, Md.
24a REC'D BY REGISTRAR DATE 10/9/56
24b REGISTRAR'S SIGNATURE Frances Fuller

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled by the funeral director page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10495

CERTIFICATE OF DEATH

10474

Reg. Dist. No. 21e

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward Middle Daniel Last Mudd

4. DATE OF DEATH: Month 10 Day 27 Year 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-11-86

9. AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardener

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel H. Mudd

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Madeline M. Killelea — Stepsister
Address: 5413 Scarsdale Rd Sumner Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Myocardial infarction, patient — 2 days.
DUE TO
(c): Coronary arteriosclerosis — 5 yrs ago.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 25 Oct., 1956, to 30 Oct., 1956, that I last saw the deceased alive on 26 Oct., 1956, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Seruch T. Kimble, M.D.
ADDRESS (Street, city or town, state): 929 Pershing Drive, Silver Spring Md.
DATE SIGNED:
PHYSICIAN'S NAME (Type): SERUCH T. KIMBLE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/29/56
22c. NAME OF CEMETERY OR CREMATORY: St Mary's Cem
22d. LOCATION (City, town or county) (State): Laurel Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Dr Wirt Davidson, Laurel, Md

24a. REC'D BY REGISTRAR DATE: 10-31-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 25M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10496 **CERTIFICATE OF DEATH**

10475 Reg. Dist. No. 214

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 9217 KINGSBURY DRIVE

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 9217 KINGSBURY DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle GUY — Last NEEL
4. DATE OF DEATH: Month OCT. — Day 11 — Year 1956
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/26/95
9. AGE (Last birthday): 61 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): LAWYER
10b. KIND OF BUSINESS OR INDUSTRY: OWN BUSINESS
11. BIRTHPLACE (State or foreign country): NEELSVILLE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JAMES BARNES NEEL
14. MOTHER'S MAIDEN NAME: KATHERINE HOYLE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW #1
16. SOCIAL SECURITY NO.: 218-20-1742
17. INFORMANT: Mrs. Lucille H. Neel, Address: 9217 Kingsbury Dr. ~~Silver Spring, Md.~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute coronary artery insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes
4 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Myocardial infarction — 22 months
DUE TO (c): Arteriosclerosis coronary arteries. — Unknown

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 19 48 to October 11 19 56, that I last saw the deceased alive on October 6 19 56, and that death occurred at 9:00 A M, from the causes and on the date stated above

ACTUAL SIGNATURE: Aaron H Traum M.D. ADDRESS (Street, city or town, state): 8237 Georgia Ave Silver Spring Md. DATE SIGNED: 10/11/56
PHYSICIAN'S NAME (Type): AARON H. TRAUM

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 10/13/56
22c. NAME OF CEMETERY OR CREMATORY: NEELSVILLE CEMETERY
22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey — ADDRESS: SILVER SPRING, MARYLAND
24a. REC'D BY REGISTRAR DATE: 10/19/56
24b. REGISTRAR'S SIGNATURE: Frances Teller

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be signed by the hospital or attending physician
TO FUNERAL DIRECTOR- After this certificate has been signed by the attending physician and completely filled by the Funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS AIS (4)
ISM 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be reta[illegible] by the hospita or attending physic an
TO FUNERAL DIRECTOR: After this certificate has been s gned by the attending physician and completely fil ed in b[illegible] funeral d rector - page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event with n 72 hours after death

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10497

CERTIFICATE OF DEATH

10476

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: District of Columbia — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural) — c. LENGTH OF STAY IN 1b: 19 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Maryland	d. STREET ADDRESS: 2017 Cathedral Ave., N.W. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Dorothy	Nicholson	NEWTON	Oct.	13	1956

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Female	White		Jan. 28, 1907	49 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housewife	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Reverdy K. Cholson	Ada Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	Unknown	(Husband) Wallace S. Newton (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Gastrointestinal hemorrhage	24 hrs
DUE TO (b)	Esophageal varices	3 mos
DUE TO (c)	Cirrhosis of the liver	2 yrs.

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 30 Sept. 1956 to 18 Oct. 1956, that I last saw the deceased alive on 18 Oct. 1956, and that death occurred at 12:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Horgan M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 10-19-56

PHYSICIAN'S NAME (Type): J. F. HORGAN, LT MC USN — U.S. Naval Hospital, Bethesda, Md. — 10-19 56

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10-22-56	Arlington Nat'l Cemetery	Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave.	Bethesda, Md.	10-18-56	Mary C. Farrell

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10498

10477

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 1 yr.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4863 Battery Lane

d. STREET ADDRESS: 4863 Battery Lane

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Katherine — Middle: C. — Last: O'Brien

4 DATE OF DEATH: Month: Oct. — Day: 30, — Year: 1956

5 SEX: ~~Married~~ Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Feb. 19, 1886

9 AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Pittsburgh, Penna

12 CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Michael A. Carmody

14 MOTHER'S MAIDEN NAME: ?

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17 INFORMANT: Harry O. O'Brien — Address: 4863 Battery Lane, Bethesda, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

420.1

DUE TO (b): congestive Heart failure — 3-4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c): arteriosclerotic coronary disease — 4-10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): hypertension, fibrillation

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour 3 P.M. — Month / Day / Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 11-28 19 56 to 12-30 19 56 that I last saw the deceased alive on 10-28 19 56 and that death occurred at 3:22 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Charles J. Savarese, Jr. M.D.

ADDRESS (Street, city or town, state): 4861 A Battery Lane, Bethesda, Md.

DATE SIGNED: 10-30-56

PHYSICIAN'S NAME (Type): Charles J. Savarese, Jr. — 4861A Battery Lane, Bethesda, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit

22b. DATE THEREOF: 10-30-56

22c. NAME OF CEMETERY OR CREMATORY: Resurrection Cem.

22d. LOCATION (City, town, or county) (State): Allegheny Co. Penna.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda, Md.

24a. RECD BY REGISTRAR (Date): 11-2-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9-55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10478

10499

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 105 days
OR INSTITUTION: The Clinical Center, National Institutes of Health, Bethesda, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: R.F.D.#4, Box 496, Woodlawn Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Helen; Middle: Mary; Last: Otto

4 DATE OF DEATH: Month: October; Day: 29; Year: 1956

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 6 February 1914

9 AGE (In years last birthday): 42 yrs
IF UNDER 1 YEAR: Months: 8; Days: 23
IF UNDER 24 HRS: Hours; Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Navy Clerk

10b KIND OF BUSINESS OR INDUSTRY: Government

11 BIRTHPLACE (State or foreign country): Connecticut

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: John Holyst

14 MOTHER'S MAIDEN NAME: Mary Lesniak

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16 SOCIAL SECURITY NO: Not available

17 INFORMANT: The Medical Record, Clinical Center, National Institutes of Health, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Metastatic adenocarcinoma of ~~Lung~~ Breast — INTERVAL BETWEEN ONSET AND DEATH: 2 years
170X
DUE TO (b): Fo Lung, Heart, Liver
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 0

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): 0

20c. TIME OF INJURY: Hour o. m. p. m.; Month; Day; Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 16, 1956, to October 29, 1956, that I last saw the deceased alive on October 29, 1956, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas Waldman M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda, Md.
DATE SIGNED: 10/30/56
PHYSICIAN'S NAME [Type]: Thomas Waldman, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/2/1956
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: 7557 Wis. Ave. Bethesda, Md.

24a REC'D BY REGISTRAR DATE: 10-31-56

24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10500

CERTIFICATE OF DEATH

10479

Reg. Dist. No 216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, Bethesda
d. STREET ADDRESS 5015 Del Ray Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Jillian Middle Eleanor Last PARENT
4. DATE OF DEATH Month 10 Day 26 Year 1956

5. SEX Female
6. COLOR OR RACE White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH 3-30-94
9 AGE (In years last birthday) 62 yrs
IF UNDER 1 YEAR Months 6 Days 25 IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11 BIRTHPLACE (State or foreign country) TENNESSEE
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME Charles Barton
14 MOTHER'S MAIDEN NAME MARY Dascee

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16 SOCIAL SECURITY NO None
17 INFORMANT Address Mrs. Ann Traimer, daughter 5015 Del Ray Ave, Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bi-lat bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 5 days
DUE TO (b) Uterine Carcinoma - wide spread metastases — 6 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Organic brain syn
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT, WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 10-23, 1956, to 10-26, 1956, that I last saw the deceased alive on 10-25, 19xx, and that death occurred at 9:20 PM, from the causes and on the date stated above
ACTUAL SIGNATURE Howard E. Tickten M.D. ADDRESS (Street, city or town, state) 2255 Wash. Ave. Silver Spring, Md. DATE SIGNED
PHYSICIAN'S NAME (Type) Howard E. Tickten

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-30-56
22c NAME OF CEMETERY OR CREMATORY Arlington National
22d LOCATION (City, town, or county) (State) Arlington, Va.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Md.
24a REC'D BY REGISTRAR DATE 10-30-56
24b REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10591 **CERTIFICATE OF DEATH** 10480

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 16 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS 510 Longwood Drive e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Robin Middle Lost Parker
4. DATE OF DEATH Month October Day 27 Year 1956

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH October 26 56
9. AGE (In years last birthday) yrs.
If UNDER 1 YEAR: Months Days Hours 10 Min 15
If UNDER 24 HRS:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY Infant
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Edward Dana Parker
14. MOTHER'S MAIDEN NAME Pearl Irene Castle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO None
17. INFORMANT Father (Same) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atelectasis, Bilateral, L.L. — INTERVAL BETWEEN ONSET AND DEATH: 4 hours + 15 Minutes
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) Hyaline Membrane Disease (?)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 26, 1956 to Oct 27, 1956, that I last saw the deceased alive on Oct 27, 1956, and that death occurred at 3:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Frank Jaccers M.D. ADDRESS (Street, city or town, state) 5707 Wisconsin Ave DATE SIGNED 10/27/56
PHYSICIAN'S NAME (Type) FRANK JACCERS Chevy Chase, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/29/1956
22c. NAME OF CEMETERY OR CREMATORY Oakwood
22d. LOCATION (City, town, or county) (State) Falls Church Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.
24a. RECD BY REGISTRAR DATE 10-30-56
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10429

CERTIFICATE OF DEATH

Reg. Dist. No 10481

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
c. LENGTH OF STAY IN 1b 2 years
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 213 Monroe St

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md.
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
d. STREET ADDRESS 213 Monroe St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Erna Middle Wagner Last Parrish

4 DATE OF DEATH Month Oct Day 16 Year 1956

5 SEX Female
6 COLOR OR RACE White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH April 8-1927
9 AGE (In years last birthday) 29 yrs
IF UNDER 1 YEAR Months 6 Days 13
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-Keeping
10b. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Frankfort, Germany
12 CITIZEN OF WHAT COUNTRY? Germany

13. FATHER'S NAME Heinrick Wagner
14 MOTHER'S MAIDEN NAME Maria Werner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO 577-42-3097
17 INFORMANT Address Harry D. Parrish- 213 Monroe St. Rockville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Convulsions — INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) Influenza — intermon
DUE TO (c) Pneumonia — 4-5 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct-13-, 1956, to Oct-16-, 1956, that I last saw the deceased alive on Oct-13-, 1956, and that death occurred at 9 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE William C. Walker M.D. ADDRESS (Street, city or town, state) Gaithersburg, Md DATE SIGNED

PHYSICIAN'S NAME (Type) William C. Walker Gaithersburg, MD

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 10-19-1956
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat.
22d LOCATION (City, town, or county) Arlington, (State) Va.

23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda Md
24a. REC'D BY REGISTRAR DATE 10/18/56
24b. REGISTRAR'S SIGNATURE Samuel Kraton Jr. Deputy

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that this death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached from page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be forwarded to the registrar prior to burial, cremation or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10502

10482

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c LENGTH OF STAY IN 1b:

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE:
b COUNTY: 8411 HARTFORD AVE SS MD.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENSINGTON NURSING HOME
d STREET ADDRESS: 3000 McCOMAS ST
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: ALEXANDER Middle: PAUL Last:
4 DATE OF DEATH: Month: 10 Day: 2 Year: 19 56

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8 DATE OF BIRTH: NOV. 21, 1874
9 AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CABINET MAKER RET.
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): RUSSIA
12 CITIZEN OF WHAT COUNTRY? U. S. A

13 FATHER'S NAME: UNKNOWN
14 MOTHER'S MAIDEN NAME: UNKNOWN

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.:
17 INFORMANT: EMILE PAUL Address: 8411 HARTFORD AVE SS MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): GENERALIZED ARTERIOSCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH:
I50.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): SENILITY
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DECUBITUS ULCUS
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Hour / a.m. p.m. / Month / Day / Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept., 19 56, to October, 19 56, that I last saw the deceased alive on Oct 1, 19 56, and that death occurred at 11.55 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Bernard A Fitzgerald M.D. ADDRESS (Street, city or town, state): 9620 Old Bladensburg Rd DATE SIGNED: 10-3-56

PHYSICIAN'S NAME (Type):

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: OCT 5, 19 56
22c NAME OF CEMETERY OR CREMATORY: MT. LEBANON
22d LOCATION (City, town, or county) (State): W HYATTSVILLE MD

23 FUNERAL DIRECTOR'S SIGNATURE: B. Benzansky & Sons ADDRESS: 3501-14th NW
24a. REC'D BY REGISTRAR DATE: 10-6-56
24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10418

10483

CERTIFICATE OF DEATH

Reg Dist. No. 223

1 PLACE OF DEATH
a. COUNTY Takoma Park MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission.)
a. STATE Maryland b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oakhaven Rest Home 517 Alban y Ave,

d. STREET ADDRESS
3707 Spring Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Helen L. Middle Ferry Last

4 DATE OF DEATH Month October Day 5, Year 1956

5 SEX female

6 COLOR OR RACE white

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH 12/9/89

9 AGE (In years last birthday) 66 yrs

IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) Batavia, New York

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME M. Considine

14. MOTHER'S MAIDEN NAME ---O'Connor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Address Records of rest Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

4-43X

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Hypertension CV disease

DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o m p m Month 0 Day Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from 1954, 19__, to 10/3/, 19 56 that I last saw the deceased alive on 10/4/, 19 56, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE Chas H Wilhelm M.D. ADDRESS (Street, city or town, state) 500 Underwood St NW DATE SIGNED

PHYSICIAN'S NAME (Type) Chas H WILHELM Wash. D C

22a. BURIAL, CREMATION, REMOVAL (Specify) burial

22b DATE THEREOF 10/8/56

22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery

22d LOCATION (City, town, or county) (State) Suitland, Md.

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Chas H Hines Co 2901-14 St N.W.

24a. REC'D BY REGISTRAR DATE 10/8/56

24b REGISTRAR'S SIGNATURE J Wilbur Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10484

Reg. Dist No. 215

10503

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 16 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Virginia Beach
d. STREET ADDRESS: 115 53rd St.,
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard; Middle: William; Last: PHILLIPS
4. DATE OF DEATH: Month: October; Day: 2; Year: 1956
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: Oct. 20, 1916
9. AGE (In years last birthday): 39 yrs
UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Aviator
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (State or foreign country): Florida
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: William Phillips
14. MOTHER'S MAIDEN NAME: Frances J. Goodman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-II
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT (Address): Official Navy Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Fatty cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a): 5 cc. laceration of right forehead (fell from bed in hospital)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. (Either)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour: 09:40 a. m. ~~p. m.~~; Month, Day, Year: 10-2- 1956
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): U.S.Naval Hospital
20f. (City or town) (County) (State): Bethesda, Montgomery, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10-2-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-8-56 b
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: R. A. Pumphrey
ADDRESS: Bethesda, Md.
R.A. Pumphrey Funeral Home, 7557 Wisc. Ave.,
24a. RECEIVED BY REGISTRAR
DATE: 10-2-56
24b. REGISTRAR'S SIGNATURE: Mary L. Connelly

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please explain. If certificate is writing the word 'pending' in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. file pages 1 and 2 with the registrar prior to burial, cremation, or removal

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

10504

CERTIFICATE OF DEATH

10485

Reg. Dist No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: A A

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: DUO. A.

c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Nat'l Naval Med. Center

d. STREET ADDRESS: 1023 Madison Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): 1. First: MARION Middle: VINCENT Last: PHIPPS

4 DATE OF DEATH: Month: OCT. Day: 26 Year: 1956

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: MARCH 21, 1938

9 AGE (In years last birthday): 18 yrs

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN

10b KIND OF BUSINESS OR INDUSTRY: BOAT YARD

11 BIRTHPLACE (State or foreign country): A A Co Md

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Frank V. Phipps

14 MOTHER'S MAIDEN NAME: Dorothy V. Phipps

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO:

17 INFORMANT: Frank V. Phipps Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 3 Weeks

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from 10-13-, 1956 to 10-26-, 1956 that I last saw the deceased alive on 10-26-, 1956, and that death occurred at 3:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James R. Martin M.D. ADDRESS (Street, city or town, state): 185 Prince George Annapolis Md DATE SIGNED: 10/26/56

PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a BURIAL, CREMATION, REMOVAL (Specify): 22b DATE THEREOF: Oct 29-56 22c NAME OF CEMETERY OR CREMATORY: HILLCREST MEMORIAL 22d LOCATION (City, town, or county): ANNAPOLIS (State): MD

23 FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Son ADDRESS: Annapolis MD

24a. RECEIVED BY REGISTRAR DATE: 10/29/56 24b REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4) ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10505

CERTIFICATE OF DEATH

10486

Reg. Dist. No 216

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda.
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda.
d. STREET ADDRESS 5510 Lincoln
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Etta Middle Last Poole.

4. DATE OF DEATH Month Oct Day 28 Year 1956.

5. SEX Fe
6. COLOR OR RACE W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 9-6-1873
9. AGE (In years last birthday) 83 yrs
IF UNDER 1 YEAR: Months 1 Days 22
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lawson Poole
14. MOTHER'S MAIDEN NAME Elizabeth Boswell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO None
17. INFORMANT Mrs. Ursula Russell, Sister Bethesda, Md. Address 5510 Lincoln St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Peritonitis. — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Carcinoma of descending Colon — 18 Mo.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardio Vascular Disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 29 April, 1955, to 28 Oct, 1956, that I last saw the deceased alive on 27 Oct, 1956, and that death occurred at 5:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE John G. Ball M.D. ADDRESS (Street, city or town, state) 7936 Georgetown Rd Bethesda Md.

PHYSICIAN'S NAME (Type) John G. Ball

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-30-56
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln
22d. LOCATION (City, town or county) (State) Prince Georges Md

23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Murphrey ADDRESS Bethesda, Md
24a. RECD BY REGISTRAR DATE 10-30-56
24b. REGISTRAR'S SIGNATURE Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10487

1050S

CERTIFICATE OF DEATH

Reg. Dist. No 26

1 PLACE OF DEATH
a COUNTY MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c LENGTH OF STAY IN 1b

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE
b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION
d STREET ADDRESS
e IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Middle Last
4. DATE OF DEATH Month Day Year 1956

5. SEX
6. COLOR OR RACE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH
9. AGE (In years last birthday) yrs
IF UNDER 1 YEAR Months 5 Days 25
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO None
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH 4 wks.

DUE TO (b) Marked anemia. 6 weeks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c) Endometrial carcinoma — Undet.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Obesity.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to Oct. 30, 1956, that I last saw the deceased alive on Oct. 25, 1956, and that death occurred at ____ A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE OF M.D. Peter A. Crowl Jr. M.D.
ADDRESS (Street, city or town, state) 104 Chevy Chase Dr. Kensington
DATE SIGNED

PHYSICIAN'S NAME (Type) Geo. A. Ray Jr.
Chevy Chase 15 Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-27-1956
22c. NAME OF CEMETERY OR CREMATORY Maple Grove Cem.
22d. LOCATION (City, town or county) Nicholasville (State) Kentucky

23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Dunphrey
ADDRESS Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE 10-27-56
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1050

CERTIFICATE OF DEATH

Reg. Dist. No. 10488 276

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION: Suburban Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12 Oldham Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Amy Middle: Kelly Last: Quisenberry
4. DATE OF DEATH: Month: Oct. Day: Year: 1956
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 23, 1885
9. AGE (In years last birthday): 71 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Edward A. Sniffin
14. MOTHER'S MAIDEN NAME: Ella Walters
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ethel A. Wills, Address: 12 Oldham Rd. Silver Sp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Infarcts both Lower lobes — INTERVAL BETWEEN ONSET AND DEATH: 2 days
180X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) Hypernephroid Ca. Rt. Kidney with — 5 yrs
DUE TO
(c) local recurrence & Metast. Lft. — 2 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1956 to Oct. 4, 1956 that I last saw the deceased alive on Oct. 4, 1956, and that death occurred at 10:45 AM, from the causes and on the date stated above.
ACTUAL SIGNATURE: Stephen R. Jones M.D
ADDRESS (Street, city or town, state): Rockville Md
DATE SIGNED: 10/5/56
PHYSICIAN'S NAME (Type): Stephen R. Jones

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Oct 8 1956
22c. NAME OF CEMETERY OR CREMATORY: Congressional
22d. LOCATION (City, town, or county) (State): Wash D C

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home Wash DC
ADDRESS:
24a. REC'D BY REGISTRAR: DATE: Oct 14
24b. REGISTRAR'S SIGNATURE: Jessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be required by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 4

VS A15 (4)
15M 9/55

10489

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10419 **CERTIFICATE OF DEATH** Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 20 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 110 St Lawrence Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: William Middle: Arthur Last: Randall
4. DATE OF DEATH Month: 10 Day: 13 Year: 1956

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min.
M	Cauc	Married ☒	Aug 11 1907	49 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bacteriologist	Food & Drug	Washington DC	USA

13. FATHER'S NAME: Vachel William Randall
14. MOTHER'S MAIDEN NAME: Blanche Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 578-16-9737
17. INFORMANT: wife Address: Mrs. M. Marie Randall, 110 St. Lawrence Drive, Silver Spring, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2-3 hours
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from ____ 19__, to 13 Oct 1956, that I last saw the deceased alive on 13 Oct 1956, and that death occurred at 4:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William D. Aud M.D.
ADDRESS (Street, city or town, state): 9 Alta Vista Rd Silver Spring Md
DATE SIGNED: 13 Oct 56
PHYSICIAN'S NAME (Type): WILLIAM D. AUD

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	10/16/56	PARKLAWN CEMETERY	MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Harvard E. Humphrey	8434 Georgia Ave Silver Spring Md	DATE 10/17/56	J. Wilson Dodd

TO HOSPITAL ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death ... may be ... by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director ... page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10456

10439

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 1y Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1006 Crawford Dr.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1006 Crawford Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: NANCIE — Middle: LEITH — Last: RAWLINGS

4 DATE OF DEATH: Month: Oct. — Day: 30 — Year: 1956

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Sept. 28, 1869

9 AGE (In years last birthday): 87 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min
1 — 2

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17 INFORMANT: Walter Leith Rawlings — Address: 1006 Crawford Dr Rockville, Md.

MED. CA. CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute left ventricular failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

DUE TO (b): Pneumonitis (viral, ? chemical) — 12 hours

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d INJURY OCCURRED White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Oct. 29, 19 56 to Oct. 30, 19 56 that I last saw the deceased alive on Oct. 29, 19 56, and that death occurred at 1 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm A. Smallwood M.D. — ADDRESS (Street, city or town, state): 110 S. Washington St. Rockville — DATE SIGNED: 10/30/56

PHYSICIAN'S NAME (Type): WILLIAM A. SMALLWOOD — 110 S. Washington St., Rockville, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit

22b DATE THEREOF: 10-30-56

22c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery

22d. LOCATION (City, town or county) (State): Loudoun County, Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Dunphrey — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 10-31-56

24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1S (4)
ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10508

10491

CERTIFICATE OF DEATH

Reg. Dist No.

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD. — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVY CHASE
d. STREET ADDRESS: 6905-MAPLE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: HELEN — Middle: M — Last: READ

4 DATE OF DEATH: Month: OCT. — Day: 2 — Year: 1956

5 SEX: Female — 6 COLOR OR RACE: White — 7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ — 8 DATE OF BIRTH: Aug 30-1868 — 9 AGE (In years last birthday): 88 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10b KIND OF BUSINESS OR INDUSTRY: None — 11 BIRTHPLACE (State or foreign country): Mass. — 12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Mr Francis Reves — 14 MOTHER'S MAIDEN NAME: Helen M. Reves

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT: Next Son-Mr. E. M. Read — Address:

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO (b): Carcinoma left breast — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from Sept 26, 1956 to Oct 2, 1956 that I last saw the deceased alive on Sept 26, 1956, and that death occurred at 7:15 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: John W Casady M.D. — ADDRESS (Street, city or town, state): 5022 Rino Rd. N.W. — DATE SIGNED: Oct 2 '56
PHYSICIAN'S NAME (Type): John W. Casady M.D.

22a. BURIAL, CREMATION, REMOVAL, Specify: CREMATION
22b DATE THEREOF: Oct. 2, 1956
22c NAME OF CEMETERY OR CREMATORY: LEES CREMATORY
22d LOCATION (City, town, or county) (State): WASHINGTON D.C.

23 FUNERAL DIRECTOR'S SIGNATURE: J. W. Lees — ADDRESS: 300-4th ST N.E WASH. D.C.
24a RECEIVED BY REGISTRAR. DATE: OCT 4 1956
24b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death may be required by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10492

Reg. Dist. No. 14

10509

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 9 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 2500 Semi ary Rd.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2500 Semi ary Rd.
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ernest — Middle: Wayne — Last: Rembert

4. DATE OF DEATH: Month: 10/21/56 — Day — Year: 19

5 SEX: male

6. COLOR OR RACE: white

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/12/1901

9 AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): executive

10b. KIND OF BUSINESS OR INDUSTRY: world bank

11 BIRTHPLACE (State or foreign country): Mo.

12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ernest E. Rembert

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW #1

16. SOCIAL SECURITY NO.: 146-09-3088

17 INFORMANT — Address: Hazel Rembert (wife) Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusio — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a).

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour, a.m. p.m. — Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D

EXAMINER'S NAME (Type): Frank J. Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 10/21/56

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 24, 1956

22c NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

22d LOCATION (City, town, or county) (State): Arlington Co., Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey — ADDRESS: Silver Spring, Md.

24a REC'D BY REGISTRAR DATE: 10/23/56

24b. REGISTRAR'S SIGNATURE: Frances Cotten

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10510 — 10493 — Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Md.
c. LENGTH OF STAY IN 1b: 202 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Davis
d. STREET ADDRESS: Box 431
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Eula — Middle: Catherine — Last: Riggleman

4 DATE OF DEATH: Month: October — Day: 16, — Year: 19 56

5 SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 26, 1912

9 AGE (In years last birthday): 43 yrs — IF UNDER 1 YEAR: Months 10 Days 20 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: School for Boys

11 BIRTHPLACE (State or foreign country): West Virginia

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Perry Riggleman

14 MOTHER'S MAIDEN NAME: Henrietta Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):

16 SOCIAL SECURITY NO: unknown

17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): brain tumor 2° to — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO: 190X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) DUE TO: metastatic malignant melanoma — 6 yrs.

(c)

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o'clock a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from March 28, 19 56 to October 16, 19 56, that I last saw the deceased alive on October 16, 19 56, and that death occurred at 920 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: L. Weissman M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 10/16/56

PHYSICIAN'S NAME (Type): S. Weissman, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-transit

22b. DATE THEREOF: 10/16/56

22c. NAME OF CEMETERY OR CREMATORY: Davis

22d. LOCATION (City, town or county) (State): Tucker Co. West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 10-18-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed by the Funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10494

Reg Dist. No. 216

10511

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: 19 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3300 Rolling Rd.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3300 Rolling Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Marguerite Middle: Bimel Last: Rightor
4 DATE OF DEATH: Month: Oct Day: 29 Year: 1956

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/2/1892
9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wm. Bimel
14. MOTHER'S MAIDEN NAME: Clara Bradly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT (Address): Chester Rightor(husband) Same # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. p. m. Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/29/56

22a. BURIAL, CREMATION, REMOVAL, OTHER (Specify): Cremation
22b. DATE THEREOF: 10/30/56
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Prince George Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 11-1-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Hampton

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Page 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSME(S) SM 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10495

10512

CERTIFICATE OF DEATH

Reg. Dist. No

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Henrico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandston
d. STREET ADDRESS: Route #1, Box 192
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clyde — Middle: Leland — Last: Robins

4. DATE OF DEATH: Month: October — Day: 5th — Year: 19 56

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 1, 1904
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Welder
10b. KIND OF BUSINESS OR INDUSTRY: Manufacturing
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Benjamin R. Robins
14. MOTHER'S MAIDEN NAME: Maggie Garthright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 223-22-1968
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cryptococcal Meningitis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 29, 19 56, to October 5, 19 56, that I last saw the deceased alive on October 5, 1956, and that death occurred at 12:47 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard K. Merchant M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 10/6/56
PHYSICIAN'S NAME (Type): Richard K. Merchant, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8 Oct 1956
22c. NAME OF CEMETERY OR CREMATORY: Washington Memorial
22d. LOCATION (City, town, or county) (State): Henrico Co., Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Henry W. Woody — Richmond, Va.
HENRY W. WOODY
24a. REC'D BY REGISTRAR DATE: OCT 8 '56
24b. REGISTRAR'S SIGNATURE

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10513

CERTIFICATE OF DEATH

10496

Reg Dist No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 2-5 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

d. STREET ADDRESS: 3926 Washington St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: KATHERINE — Middle: M — Last: ROGERS

4. DATE OF DEATH: Month: Oct. — Day: 2 — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 10, 1881

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months: 3 — Days: 22

IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Ostrander

14. MOTHER'S MAIDEN NAME: Julia A. Broadwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Helen G. Ostrander-3504 Fairview Ave. Balt Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Hypertension, essential — Unknown

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-26, 1956, to 10-2, 1956, that I last saw the deceased alive on 10-2, 1956, and that death occurred at 3:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Morris Perry M.D. — ADDRESS (Street, city or town, state): 1662 Georgia Ave. Silver Spring Md — DATE SIGNED: 10-2-56

PHYSICIAN'S NAME (Type): Morris Perry

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial Tr.

22b. DATE THEREOF: 10-4-56

22c. NAME OF CEMETERY OR CREMATORY: Esperance, N.Y.

22d. LOCATION (City, town, or county) (State): Esperance New York

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda Md

24a. REC'D BY REGISTRAR DATE: 10-2-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10497

10514

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1 PLACE OF DEATH: 5519 Sonoma Rd Bethesda Md
COUNTY: Montgomery MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
LENGTH OF STAY (in this place): 16 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5519 Sonoma Rd.

2 USUAL RESIDENCE (HOME) OF DECEASED: 5519 Sonoma Rd. Bethesda Md.
STATE: Md COUNTY: Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Bethesda
STREET ADDRESS (If rural give location): 5519 Sonoma Rd.

3 NAME OF DECEASED (Type or Print): (First) Carrie (Middle) May (Wanamaker) (Last) Rowe

4. DATE OF DEATH: (Month) Oct (Day) 30 (Year) 1956

5 SEX: F

6 COLOR OR RACE: W

7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8 DATE OF BIRTH: 27 Aug 1874

9 AGE last birthday: 82 yrs (IF UNDER 1 YEAR: Months | Days; IF UNDER 24 HRS.: Hours | Min.)

10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife

10B KIND OF BUSINESS OR INDUSTRY: —

11 BIRTHPLACE (State or foreign country): Mt Carmel, Pa.

12 CITIZEN OF WHAT COUNTRY? U S

13 FATHER'S NAME: Jacob Wanamaker

14 MOTHER'S MAIDEN NAME: Mary Elizabeth Rupp

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service): —

16 SOCIAL SECURITY NO: Unk

17 INFORMANT'S ADDRESS: Corinne A. Rowe-daughter - Address same

18 MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) DUE TO: Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSE (B) DUE TO: —

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C): —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Hypertension and arteriosclerotic heart disease — 10 years

19A. DATE OF OPERATION: Bone Marrow Jan 1956

19B. MAJOR FINDINGS OF OPERATION: Multiple myeloma

20. AUTOPSY? YES ☒

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) M

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1956, to 30 Oct, 1956, that I last saw the deceased alive on 29 Oct, 1956, and that death occurred at 7:35 A.M., from the causes and on the date stated above.

SIGNATURE: Harry G. Haverstman, Jr. - M. D. ADDRESS: 1835 E 9e St NW. Wash DC. DATE SIGNED: 30 Oct 56

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — DATE THEREOF: 11/2/56 — NAME OF CEMETERY OR CREMATORY: Emerald Hill — LOCATION (City, town, or county) (State): Ovila, Pa

DATE REC'D BY LOCAL REGISTRAR: 10-30-56 — REGISTRAR'S SIGNATURE: Bessie M. Thompson — 24 FUNERAL DIRECTOR: Warner E. Pumphrey — ADDRESS: 8434 Ga Ave

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10515

CERTIFICATE OF DEATH

10498

Reg. Dist No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8103 Hampden Lane
d. STREET ADDRESS: 8103 Hampden Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: KATE — Middle: ROY — Last: RYLAND

4. DATE OF DEATH: Month: Oct. — Day: 9, — Year: 19 56

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 8, 1878
9. AGE (in years last birthday): 78 yrs
IF UNDER 1 YEAR: Months: — Days: 1
IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interior ~~xxxxxxxx~~ decorating
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: ~~Xxxxx~~ Garrett, Katherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Percy Ryland- Item # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinoma, Ethmoid — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO (b): Cirrosis Myocarditis — 2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Hypertension Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/10/57 19___ to 10/9 1956, that I last saw the deceased alive on 10/9 19 56, and that death occurred at 2 15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A C Leonardo M.D.
ADDRESS (Street, city or town, state): 5801-13th St. NW.
DATE SIGNED: 10/9/56

PHYSICIAN'S NAME (Type): Alexander C. Leonardo 5801 13th. St., N.W. Wash., D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-11-56
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town or county) (State): Prince George Co., Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey-Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 10-11-56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then page 3 case remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A3S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10420

CERTIFICATE OF DEATH

10499

Reg. Dist. No. 223

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Pk

c. LENGTH OF STAY IN 1b: 4 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D C

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium Hospital

d. STREET ADDRESS: Takoma Park, Md. 921-Eye Nw

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: John Middle: — Last: Saris

4. DATE OF DEATH: Month: October Day: 11, Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/18/8[illegible]

9. AGE (In years on last birthday) 68 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION. Give kind of work done during most of working life (even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Turkey

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Athanasios Saris

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown): Unk — If yes, give war or dates of service:

16. SOCIAL SECURITY NO.: 577-12-7626

17. INFORMANT: Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 10 mo.

162 X

DUE TO

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Heavy cigarette smoker

DUE TO

(c)

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 1948, 19—, to Oct. 11, 1956 that I last saw the deceased alive on Oct. 11, 1956 and that death occurred at 9:00 M, from the causes and on the date stated above

ACTUAL SIGNATURE: Oliver E. Thompson M.D. — ADDRESS (Street, city or town, state): 1835 Eye Street N. W. Wash. D. C. — DATE SIGNED

PHYSICIAN'S NAME (Type): Oliver E. Thompson, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/15/56

22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

22d. LOCATION (City, town, or county): Washington (State) D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Frank Sweet Sons Co — ADDRESS: 3605-14 8th N W Wash. D C

24a. REC'D BY REGISTRAR DATE: 10/17/56

24b. REGISTRAR'S SIGNATURE: J. Richard Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be obtained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10516

CERTIFICATE OF DEATH

10590

Reg Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda Rural
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: District of Columbia — COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 2048 Garfield Terrace NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Roland — Middle: Weyburn — Last: SCHUMANN

4 DATE OF DEATH: Month: October — Day: 9 — Year: 1956

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-30-56 1882-
9 AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b KIND OF BUSINESS OR INDUSTRY: Mariner Retired
11 BIRTHPLACE (State or foreign country): New York
12 CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: George SCHUMANN
14 MOTHER'S MAIDEN NAME: Charlotte WEYBURN

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes — WW I & II
16 SOCIAL SECURITY NO: Unknown
17 INFORMANT: Address: Spn CDR Roland SCHUMANN, 4418 Stanford Street, Chevy Chase, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thrombosis, anterior cerebral artery — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH, IF EITHER NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I attended the deceased from 7 Oct 19 56 to 9 Oct 19 56 that I last saw the deceased alive on 9 Oct 19 56, and that death occurred at 9:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H.E. RICHARDSON, CAPT, MC, USN M.D. — ADDRESS (Street, city or town, state): USNH, NNMC, Bethesda, Maryland — DATE SIGNED: 10-10-56

PHYSICIAN'S NAME (Type): H. E. RICHARDSON CAPT MC USN — USNH, NNMC, Bethesda, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 10-12-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl Cemetery
22d LOCATION (City, town or county) (State): Arlington, Virginia

23 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R.A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, Maryland
24a REC'D BY REGISTRAR DATE: 10 Oct 56
24b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be reta ed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled n by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

YS A15 (4)
35M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10517

CERTIFICATE OF DEATH

Reg. Dist. No. 10501 21

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND
2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C. b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg
c. LENGTH OF STAY IN 1b 2 yrs.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Asbury Methodist Home
d STREET ADDRESS 1725 17 th st. N.W.
e RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First MIRIAN Middle FAIRCHILD Last SHERMAN
4 DATE OF DEATH Month October Day 6 Year 1956

5. SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9 AGE In years last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
female	white		1-8-1880	76 yrs.				

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) secretary
10b. KIND OF BUSINESS OR INDUSTRY WYCA
11 BIRTHPLACE (State or foreign country) Ash Grove, Va.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME Franklin Sherman
14 MOTHER'S MAIDEN NAME Caroline M. Alvord

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 577-26-8448
17 INFORMANT Asbury Home records Address Gaithersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) CEREBRAL VASCULAR ACCIDENT — 4 days
DUE TO
(c) ARTERIOSCLEROSIS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d INJURY OCCURRED While at work ☐ Not while at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21. I certify that I attended the deceased from JANUARY, 1956 to October, 1956 that I last saw the deceased alive on October 5, 1956, and that death occurred at 10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Sarah E. Glover M.D. ADDRESS (Street, city or town, state) 4208 Anthony St Kensington, Md. DATE SIGNED 10-6-56
PHYSICIAN'S NAME (Type) Sarah E. Glover

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10-10-56
22c NAME OF CEMETERY OR CREMATORY Arlington Memorial Park
22d LOCATION (City, town, or county) Arlington (State) Va.

23. FUNERAL DIRECTOR'S SIGNATURE Ernest B. Fortin ADDRESS Gaithersburg Md.
24a. REC'D BY REGISTRAR DATE OCT 9 - 56
24b REGISTRAR'S SIGNATURE Virginia G. Cook

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10518 — 10502 — Reg. Dist. No. 217

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 1 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Home

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md — b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print): First: Lizzie — Middle: Virginia — Last: Sturley
4 DATE OF DEATH: Month: Oct — Day: 14 — Year: 1956

5. SEX: Female — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 6-12-87 — 9. AGE (In years last birthday): 69 yrs. — UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework — 10b. KIND OF BUSINESS OR INDUSTRY: Own Home — 11. BIRTHPLACE (State or foreign country): Va — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Not Known — 14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT — Address: Mrs Sturley Rockville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO (b): Hypostatic pneumonia — 1 hr

DUE TO (c): 0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year, 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Paul J. Bryant M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 10-14-56

EXAMINER'S NAME (Type): PAUL J. BRYANT.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Oct 17, 1956 — 22c. NAME OF CEMETERY OR CREMATORY: Lewinsville — 22d. LOCATION (City, town, or county) (State): Lewinsville Va

23. FUNERAL DIRECTOR'S SIGNATURE: Pearson Funeral Home — ADDRESS: Falls Church Va — 24a. REC'D BY REGISTRAR: DATE OCT 17 1956 — 24b. REGISTRAR'S SIGNATURE: Gertrude B Lawler

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary please execute this certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR. Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the registrar prior to burial, cremation, or removal

VS A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10519

10503

CERTIFICATE OF DEATH

Reg. Dist. No 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, NNMC, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 212 Monroe Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Rochester — Middle: Ford — Last: SIMS

4 DATE OF DEATH: Month: October — Day: 5 — Year: 1956

5 SEX: Male

6 COLOR OR RACE: Caucasian

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 22 April 1897

9 AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Correspondence secretary
10b. KIND OF BUSINESS OR INDUSTRY: D.C. Government
11 BIRTHPLACE (State or foreign country): CHINA
12 CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Earle David SIMS
14. MOTHER'S MAIDEN NAME: Vivia DIVERS

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes ✓ (If yes, give war or dates of service): WW I
16 SOCIAL SECURITY NO: 577 07 6525
17 INFORMANT — Address: Mrs. Thelma Mae SIMS, same as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Uncertain

410 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) Rheumatic heart disease with mitral insufficiency

DUE TO

and tricuspid insufficiency

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a m / p m — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 18 Sept. 1956 to 5 Oct. 1956 that I last saw the deceased alive on 5 Oct. 1956, and that death occurred at 6:55 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry A Schlang M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 10-6-56

PHYSICIAN'S NAME (Type): H. A. SCHLANG, CDR, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 10-8-56
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l, Arl. Va
22d LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: D. C.
Chambers Funeral Home, 3072 M. St., N.W. Wash.

24a. REC'D BY REGISTRAR — DATE: 10-5-56
24b. REGISTRAR'S SIGNATURE: Mary E. Farrell

TO HOSPITAL ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled out, the funeral director should detach page 3 and 4 and file with the registrar. Pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10504

10421

CERTIFICATE OF DEATH

Reg. Dist No. 223

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 week
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. & Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: D. C. — b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d STREET ADDRESS: 1211 Delafield Pl. N. W.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Frederick — Middle Emmett — Last Smith

4 DATE OF DEATH: Month October — Day 10 — Year 1956

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 22, 1893
9 AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lab. Bur. of Eng.
10b KIND OF BUSINESS OR INDUSTRY: Pharmacist
11 BIRTHPLACE (State or foreign country): Washington D. C.
12 CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Robert Smith
14. MOTHER'S MAIDEN NAME: Rosalie Harman

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17 INFORMANT: Address: Emily G. Smith 1211 Delafield Pl. N.W.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Wk
DUE TO (b): Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — DUE TO (c): Parkinson's Syndrome — 10 yrs
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
2602
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): 10 yrs
20c. TIME OF INJURY Month, Day, Year, Hour o m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 1954, 19__, to 10/10/56, 19__, that I last saw the deceased alive on 10/10/56, 19__, and that death occurred at 7:45 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas M. Wilson — M.D. — ADDRESS (Street, city or town, state): 5000 Nebraska Ave. NW Wash. DC — DATE SIGNED: 10/11/56

PHYSICIAN'S NAME (Type): Chas M. Wilson — Washington DC

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Oct. 13, 1956
22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill
22d. LOCATION (City, town or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Deal Funeral Home 4812 Georgia Ave. N.W. Wash. D. C.
24a. REC'D BY REGISTRAR DATE: 10/13/56
24b. REGISTRAR'S SIGNATURE: J. Hilton Deal

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be left by the hospital or attending physician
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10505

10520 **CERTIFICATE OF DEATH** Reg. Dist. No. 216

1 PLACE OF DEATH a COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 95 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE: Virginia b COUNTY: Alexandria
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Alexandria
d STREET ADDRESS: 100 East Oak Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Iva Middle Brown Last Smith
4 DATE OF DEATH: Month October Day 4, Year 19 56

5. SEX: Female
6. COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: September 9, 1890
9 AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10b KIND OF BUSINESS OR INDUSTRY: Nursing
11 BIRTHPLACE (State or foreign country): Virginia
12 CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: James Moriarty
14 MOTHER'S MAIDEN NAME: Elizabeth Lanham

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.: 226-48-2242
17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Pulmonary edema, acute	1 day
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)	Acute leukemic crisis	1 week
DUE TO (c)	Chronic myelogenous leukemia	1½ - 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a): cholelithiasis
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 19 56 to October 4, 19 56 that I last saw the deceased alive on October 4, 19 56, and that death occurred at 4:20 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Jarvis E Seermiller M.D.
PHYSICIAN'S NAME (Type): Jarvis E. Seermiller, M. D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 10/4/56

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/6-56
22c. NAME OF CEMETERY OR CREMATORY: Nath. Mem. B. Park
22d. LOCATION (City, town, or county) (State): Falls Church Va

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. Demmin & Son
ADDRESS:
24a REC'D BY REGISTRAR DATE: 10/6 56
24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician and completely filled in by the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

TO WHOM IT MAY CONCERN:

Patient requested last name to be changed from: Iva Brown Gilliland, to Iva Brown Smith, through her son, prior to death.

1

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10521

CERTIFICATE OF DEATH

Reg Dist No. 10506

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney
c. LENGTH OF STAY IN 1b 3 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharon Chronic Hosp-

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 3016-43rd St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Eva Middle Anna Last Snyder
4 DATE OF DEATH Month October Day 9 Year 1956

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Aug. 30 1862
9. AGE (In years last birthday) 94 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Whitfield N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.-A

13. FATHER'S NAME Lyma Smith
14. MOTHER'S MAIDEN NAME ? Saunders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT (Name, address, and relationship) Mrs. Wm R. Vallance Davt. 3016 - 43rd St. N.W. Wash-D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Disease
DUE TO (b) Generalized Arteriosclerotic Heart Dis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 19 56 to Oct. 9 19 56 that I last saw the deceased alive on October 8 19 56, and that death occurred at 7:10 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE Charleen G Kirkpatrick M.D. ADDRESS (Street, city or town, state) 1726 Eye St. N.W. Wash 6, D.C. DATE SIGNED Oct. 9, 1956

PHYSICIAN'S NAME (Type) CHARLEEN G. KIRKPATRICK, M.D., 1726 Eye St NW, Washington, DC

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/9/56
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
22d. LOCATION (City, town, or county) (State) Herkimer New York

23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler Sons ADDRESS Wash. D.C.
24a. REC'D BY REGISTRAR DATE 10/10/56
24b. REGISTRAR'S SIGNATURE Janice Kaylor

March 25

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10522

CERTIFICATE OF DEATH

Reg. Dist. No. 216 10507

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase

c. LENGTH OF STAY IN 1b: 29 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4613 Langdrum Lane

d. STREET ADDRESS: 4613 Langdrum Lane

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Charles Middle: Henry Last: Squire

4 DATE OF DEATH: Month: October Day: 16 Year: 1956

5 SEX: male

6 COLOR OR RACE: white

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 13,1871

9 AGE (In years last birthday): 85 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Judge, Probate Court, Mont. Co.

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Illinois

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unobtainable

14 MOTHER'S MAIDEN NAME: unobtainable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: - -

17 INFORMANT: Address: Chevy Chase, Md. Mrs. Charles H. Squire 4613 Langdrum Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): [illegible]

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): [illegible]

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE [illegible] M.D.

PHYSICIAN'S NAME (Type): Bradley D. Hodgkins

22a BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10/17/56

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory

22d LOCATION (City, town, or county) (State): Prince Geo. County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co., 2901 14th St. N.W.

ADDRESS: Wash, D.C.

24a. REC'D BY REGISTRAR DATE: 10-18-56

24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10523

CERTIFICATE OF DEATH

10508

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Nursing Home

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: DC — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, 7
d. STREET ADDRESS: 3517 - Davis Street NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: Joseph — Last: Stanton

4. DATE OF DEATH: Month: Oct. — Day: 3 — Year: 1956

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 23, 1874
9 AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months: 11 — Days: 3
IF UNDER 24 HRS: Hours: — Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.
11 BIRTHPLACE (State or foreign country): New York
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: William Stanton
14 MOTHER'S MAIDEN NAME: Margaret Prendergast

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.:
17 INFORMANT (Address): Walter C. Stanton - Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO (b): Arteriosclerosis — Senility — 3 yrs
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Senility — yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month: — Day: — Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f (City or town) (County) (State):

21 I certify that I attended the deceased from 9/15/56, 19__, to 10/3/56, 19__, that I last saw the deceased alive on 10/2/56, 19__, and that death occurred at 11:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Samuel Allen M.D. M.D. — ADDRESS (Street, city or town, state): Kensington, Md. — DATE SIGNED: 10/4/56

PHYSICIAN'S NAME (Type): SAMUEL Allen M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Oct. 6, 1956
22c. NAME OF CEMETERY OR CREMATORY: Gate Of Heaven Cem.
22d LOCATION (City, town, or county) (State): Silver Spring, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: H. Don. Welch — ADDRESS: 2224 - Wis. N.W.
24a. REC'D BY REGISTRAR, DATE: 10-6-56
24b REGISTRAR'S SIGNATURE: Bessie M. Harrison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 1

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10509

10422

CERTIFICATE OF DEATH

Reg Dist. No. 223

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK

c. LENGTH OF STAY IN 1b: 4 yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8519 GLENVIEW AVE.

d. STREET ADDRESS: 8519 GLENVIEW AVE.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: LeROY — Middle: B. — Last: STAFLEFORD

4 DATE OF DEATH: Month: OCTOBER — Day: 12 — Year: 19 56

5. SEX: MALE

6 COLOR OR RACE: WHITE

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: MARCH 6, 1911

9 AGE (In years last birthday): 45 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): METEROLOGIST, Weather Bureau U. S. GOV'T.

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Lowell, Mass.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ERNEST STAPLEFORD

14. MOTHER'S MAIDEN NAME: THERESA M. HOWE

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW #2

16. SOCIAL SECURITY NO: YES

17 INFORMANT: Mrs. Anna Marie Stapleford — Address: 8519 Glenview Ave. Takoma Park, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

U.D.I

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from Aug 19 56 to Oct 12 19 56 that I last saw the deceased alive on Oct 12 19 56, and that death occurred at 3:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Raymond O. West M.D. — ADDRESS (Street, city or town, state): 7000 Carroll Ave, Tak Pk Md — DATE SIGNED

PHYSICIAN'S NAME (Type): RAYMOND O. WEST

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 10/15/56

22c NAME OF CEMETERY OR CREMATORY: NEW PAWTUXET CEMETERY

22d LOCATION City, town or county (State): PROVIDENCE, RHODE ISLAND

23 FUNERAL DIRECTOR'S SIGNATURE: Warren E. Pumphrey — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: 10/16/56

24b REGISTRAR'S SIGNATURE: J. Wilson Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10524

10510

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 2 16

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 10614 Wheatley Street

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 10604 Wheatley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH Middle H. Last STOCKDALE
4. DATE OF DEATH: Month October Day 26, Year 1956

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 31, 1882
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months 9 Days 25
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Wool Industry
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 285-07-2979
17. INFORMANT: A) Margaret A. Stockdale-Item # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Aricular fibrillation — 2 yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): Frank J. Broschart, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 10/26/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 10/29/56
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Prince Georges Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.
24a. REC'D BY REGISTRAR DATE: 10/30/56
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain. Page 4 should be completed by the Deputy Medical Examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10511

10525 CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Monta MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
LENGTH OF STAY (In this place) 60 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kensington
STREET ADDRESS (If rural, give location) 3002 Edmund Rd

3. NAME OF DECEASED (Type or Print) (First) Evelyn (Middle) Mudd (Last) Stone

4. DATE OF DEATH (Month) 10 (Day) 27 (Year) 1956

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH 5/24/1880

9. AGE Last birthday 76 yrs. If under 1 year Months. Days. If under 24 hrs. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. W.

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY U.S.

13. FATHER'S NAME Stephen Mudd

14. MOTHER'S MAIDEN NAME Alice Luffler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS Mrs Evelyn Mudd Stone Kensington

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) (1) Cerebral Hemorrhage Acute — Interval Between Onset and Death: 12 hrs.

Antecedent cause(s) (b) (2) Arteriosclerosis — Senility — yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) (3) Senility — yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950 to 10/27/56, that I last saw the deceased alive on 10/26/56, and that death occurred at 9:45 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 10/30/56 NAME OF CEMETERY OR CREMATORY Oak Hill Cem LOCATION (City, town, or county) Wash DC (State)

DATE REC'D BY LOCAL REG. 10/29/56 REGISTRAR'S SIGNATURE Frances Cotter

24. FUNERAL DIRECTOR ADDRESS W. R. Huntemann & Son 5732 Hamm

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10512

10526

CERTIFICATE OF DEATH

Reg Dist. No. 2 / 6

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kenwood

c. LENGTH OF STAY IN 1b: 60 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kenwood

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5221 Kenwood Ave.

d. STREET ADDRESS: 5221 Kenwood Ave.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HATTIE — Middle: J. — Last: STRCIAL

4. DATE OF DEATH: Month: Oct. — Day: 22, — Year: 1956

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Apr. 5, 1873 — 9. AGE (In years last birthday): 83 yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife — 10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - - - — 11. BIRTHPLACE (State or foreign country): Rolla, Missouri — 12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Benjamin Culbertson — 14. MOTHER'S MAIDEN NAME: Harriett ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): No — 16. SOCIAL SECURITY NO.: none — 17. INFORMANT: Daughter, Mrs. J.L. Jerman — Address: 5221 Kenwood Ave. Kenwood, Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinomatosis of the pancreas — INTERVAL BETWEEN ONSET AND DEATH: 4 Months

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1, 19 56, to Oct 22, 19 56, that I last saw the deceased alive on Oct 21, 1956, and that death occurred at 12 M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Robert Perkins, M.D. — ADDRESS (Street, city or town, state): 1413 Rhode Island Ave. Washington, D.C. — DATE SIGNED: 10/24/56

PHYSICIAN'S NAME (Type): W. Robert Perkins

22a. BURIAL, CREMATION, REMOVAL (Specify): Interment — 22b. DATE THEREOF: 10-30-56 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — 22d. LOCATION (City, town, or county) (State): Prince George's Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. MURPHEY — ADDRESS: Bethesda, Md. 7557 Wis. Ave. — 24a. REC'D BY REGISTRAR DATE: 10-30-56 — 24b. REGISTRAR'S SIGNATURE: Pearle M. Johnson, Asst.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event with in 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10527

CERTIFICATE OF DEATH

10513

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda, (Rural)
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cabin John
d. STREET ADDRESS: 8115 Riverside Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Ann — Last: SWEITZER

4. DATE OF DEATH: Month: October — Day: 1 — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 3, 1940

9. AGE (In years last birthday): 16 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Alvie Howard SWEITZER

14. MOTHER'S MAIDEN NAME: Martha LEWIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: (Father) Alvie H. Sweitzer (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): —
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): —
DUE TO
(c): Acute lymphatic leukemia — Ca 11 months
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Staphylococcal Septicemia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 23, 19 56, to Oct. 1, 19 56, that I last saw the deceased alive on Oct. 1, 1956, and that death occurred at 7:45 A. M. from the causes and on the date stated above

ACTUAL SIGNATURE: Russell Miller Jr. M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 10-1-56

PHYSICIAN'S NAME (Type): Russell Miller, Jr. LT.MC.USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-2-56
22c. NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park
22d. LOCATION (City, town or county) (State): Frostburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Rumphrey — ADDRESS: R.A. Rumphrey Funeral Home, 7557 Wisconsin Ave. Bethesda, Md.

24a. REC'D BY REGISTRAR — DATE: 10-1-56
24b. REGISTRAR'S SIGNATURE: Mary C. Tassell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be returned by the hospital or attending physician on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10514

CERTIFICATE OF DEATH

10528 Reg. Dist. No

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 7hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 4119 Sampson Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Floonie Middle New Last TENNANT
4. DATE OF DEATH Month 10 Day 15 Year 1956
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11-28-05
9. AGE (In years last birthday) 50 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician
10b. KIND OF BUSINESS OR INDUSTRY US Government
11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Richard K. Tennant
14. MOTHER'S MAIDEN NAME Ella Hughes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT Address Mrs. Arlene Tennant - above

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Acute — INTERVAL BETWEEN ONSET AND DEATH: 9 hours.
DUE TO (b) Coronary Sclerosis — 2 years
DUE TO (c) Arteriosclerosis — 2 years
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 15, 1956 to Oct. 15, 1956 that I last saw the deceased alive on Oct. 15, 1956, and that death occurred at 7:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert G. Angle M.D. ADDRESS (Street, city or town, state) 5009 Dorset Ave. Bethesda, Md. DATE SIGNED 10/15/56
PHYSICIAN'S NAME (Type) Robert G. Angle

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 10/17/56
22c. NAME OF CEMETERY OR CREMATORY Parklawn
22d. LOCATION (City or town, or county) (State) Rockville Md.

23 FUNERAL DIRECTOR'S SIGNATURE W W Chambers Co ADDRESS Riverdale, Md. 5801 Cleveland Ave
24a. RECEIVED BY REGISTRAR DATE 10/18/56
24b. REGISTRAR'S SIGNATURE

VS A15 (4) 15M 9/55

TO [redacted] HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours of death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10529

CERTIFICATE OF DEATH

10515

Reg. Dist. No. 246

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Md.

c. LENGTH OF STAY IN 1b: 5 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmont

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 1042½ Morgantown Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Howard Middle: Leo Last: Truban

4 DATE OF DEATH: Month: October Day: 1, Year: 19 56

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 29, 1923

9 AGE (In years last birthday): 33 yrs. IF UNDER 1 YEAR: Months 1 Days 2 IF UNDER 24 HRS: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpet Layer

10b KIND OF BUSINESS OR INDUSTRY: Furniture Co.

11 BIRTHPLACE (State or foreign country): West Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Toby Truban

14 MOTHER'S MAIDEN NAME: Nora Paugh

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 236-32-5439

17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Peripheral Shock — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Blood Loss — 6 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Familial Typical Hemolytic anemia — Life long

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Splenomegaly and Splenectomy

19 WAS A TOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o'clock a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)

21. I certify that I attended the deceased from September 26 19 56 to October 1, 19 56 that I last saw the deceased alive on October 1, 19 56, and that death occurred at 7:00 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Dr Rudi Schmid M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 10/2/56

PHYSICIAN'S NAME (Type): Rudi Schmid, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Bur-transit

22b. DATE THEREOF: 10/6/1956

22c. NAME OF CEMETERY OR CREMATORY: Holy Cross

22d LOCATION (City, town, or county) (State): Fairmont West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 10-2-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10423

10516

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Cedar Haven Rest Home 7300 Baltimore Ave.

d. STREET ADDRESS: 1530 Newton St. N.E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First Louise Middle C. Last Vail

4 DATE OF DEATH: Month October Day 11 Year 1956

5 SEX: female

6. COLOR OR RACE: white

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6/5/80

9 AGE In years (last birthday): 76 yrs

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Ontario, Canada

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Colborne

14. MOTHER'S MAIDEN NAME: Martha L.----

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT Address: Rest Home Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congestive Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

DUE TO (b): Arteriosclerotic cardiovascular disease — 1 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 1 19 55 to Oct 11 19 56 that I last saw the deceased alive on Oct 10 19 56, and that death occurred at 2:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Francis P. Hammann M.D. ADDRESS (Street, city or town, State): 1511-17 H St N.W. Wash D.C. DATE SIGNED: Oct 11 1956

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 10/13/56

22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

22d LOCATION (City, town or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The S.H. Hines Co. 2901 11th St. N.W. Washington, D.C.

24a. REC'D BY REGISTRAR DATE: 10/15/56

24b. REGISTRAR'S SIGNATURE: Hilton Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician on

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10424

CERTIFICATE OF DEATH

10517

Reg. Dist. No. 223

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 58 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 113 Oxford St., Chevy Chase
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: Elizabeth; Middle: Hamilton; Last: Vance

4 DATE OF DEATH: Month: 10 — Day: 28 — Year: 1956

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8 DATE OF BIRTH: 6-6-71

9 AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country): Pa.

12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Hamilton

14 MOTHER'S MAIDEN NAME: Margaret Armstrong

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16 SOCIAL SECURITY NO

17 INFORMANT: Address: Washington Sanitarium & Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	RESPIRATORY FAILURE	7 DAYS
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	GENERALIZED ARTERIOSCLEROSIS	8-10 YRS.
DUE TO (c)	CANCRENE LEFT LOWER EXTREMITY	5 MOS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 1955 to October 1956 that I last saw the deceased alive on October 27 1956, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold Sterling M.D.

ADDRESS (Street, city or town, state): 1352 UNIVERSITY LANE

DATE SIGNED

PHYSICIAN'S NAME (Type): HAROLD STERLING 1352 University Lane, Hyattsville, Md

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 10/31/56

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d LOCATION (City, town or county) (State): Washington D.C.

23 FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons

ADDRESS: 1756 Pa. Ave. N.W.

24a. REC'D BY REGISTRAR DATE: 10/31/56

24b REGISTRAR'S SIGNATURE: J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10539

CERTIFICATE OF DEATH

10518

Reg Dist No 216

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: D. C. — b COUNTY:

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

d. STREET ADDRESS: 4120 HARRISON ST. NW

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle C. — Last VAN VLECK

4. DATE OF DEATH: Month October — Day 12 — Year 1956

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/11/1885

9 AGE (In years last birthday): 70 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b KIND OF BUSINESS OR INDUSTRY: Professor

11 BIRTHPLACE (State or foreign country): Wash., D.C.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM H. VanVleck

14. MOTHER'S MAIDEN NAME: MARTHA SHINN

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17 INFORMANT (Address): JENNIE VAN VLECK SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 14 days

DUE TO

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last: (b) Cardio-Vascular Renal Disease — 5 yrs.

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture right hip

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Fell in home

20c TIME OF INJURY: Hour a.m. p.m. — Month 9 — Day 27 — Year 19[illegible]

20d INJURY OCCURRED: While at work ☐ Not while at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.): Home

20f (City or town) (County) (State): Wash. D.C.

21. I certify that I attended the deceased from Sept. 27, 1956, to Oct. 12, 1956, that I last saw the deceased alive on October 2, 1956, and that death occurred at 9:20 PM, from the causes and on the date stated above

ACTUAL SIGNATURE: Sidney C Cousins M.D. — ADDRESS (Street, city or town, state): 3921 Lowell St NW — DATE SIGNED: 10/12/'56

PHYSICIAN'S NAME (Type): SIDNEY C COUSINS — Wash D C

22a BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10/15/56

22c NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

22d LOCATION (City, town or county) (State): Suitland, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Hyde Funeral Home — ADDRESS: Washington, D.C.

24a. REC'D BY REGISTRAR DATE: 10-16-56

24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN- The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10531

10519

Reg. Dist No. 215

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)

c. LENGTH OF STAY IN 1b 5 mos.26 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.

d. STREET ADDRESS U.S. Naval Hosp. (Nurses Qtrs.)

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Lucille Middle: Henrietta Last: VOSGERAU

4. DATE OF DEATH Month: October Day: 12 Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-23-1909

9. AGE (In years last birthday) 46 yrs.

IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Otto Henry Vosgerau

14. MOTHER'S MAIDEN NAME: Margaret Amanda Boettger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-II

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT Address: (Mother) Mrs. Margaret Vosgerau, Dennison, Iowa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Adenocarcinoma, left kidney with metastases — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 16 April, 1956, to October 12, 19 56, that I last saw the deceased alive on 12 Oct. / 1 / 19 56, and that death occurred at 0420A M, from the causes and on the date stated above

ACTUAL SIGNATURE: A. J. Johnson M.D. ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. DATE SIGNED: 10-12-56

PHYSICIAN'S NAME (Type): A. J. JOHNSON, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 16 Oct. 1956

22c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery

22d. LOCATION (City, town, or county) (State): Dennison, Iowa

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey ADDRESS: Bethesda, Md.

R.A. Pumphrey Funeral Home, 7557 Wisconsin Ave.

24a. REC'D BY REGISTRAR DATE: 10-12-56

24b. REGISTRAR'S SIGNATURE: Mary E. Connelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be related by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event with in 72 hours after death

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

10520

CERTIFICATE OF DEATH

10532 Reg. Dist. No. 21

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dickerson
d. STREET ADDRESS: Route #1
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Octavia — Middle: — Last: WARFIELD
4. DATE OF DEATH: Month: October — Day: 18 — Year: 1956
5. SEX: FEMALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 7/30/05
9. AGE (In years last birthday): 51 yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: WALTER PRATHER
14. MOTHER'S MAIDEN NAME: RACHEL BOYD
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: DAUGHTER — Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Uremic Pneumonitis & Congestive Heart Failure	
DUE TO (b)	Hypertensive Heart Disease	?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c)	Glomerulonephritis, Subacute -	?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg. etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10-12-56 19___ to 10-16 19 56 that I last saw the deceased alive on 10-14 19 56, and that death occurred at 5 P M, from the causes and on the date stated above

ACTUAL SIGNATURE: Harris Perry M.D. — ADDRESS (Street, city or town, state): 11607 Georgia Ave Silver Spring Maryland — DATE SIGNED: 10-18-56

PHYSICIAN'S NAME (Type): Harris Perry

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/22/56
22c. NAME OF CEMETERY OR CREMATORY: Brooke Grove.
22d. LOCATION (City, town, or county) (State): Laytonsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: R. L. Snowden. — ADDRESS: Rockville, Md.
24a. RECD BY REGISTRAR DATE: 10 5
24b. REGISTRAR'S SIGNATURE: Lizzie V. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10533 10521

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY Baltimore — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson
c. LENGTH OF STAY IN 1b: 25 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maryland Training School

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md. — b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe
d. STREET ADDRESS Old Frederick Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henry — Middle William — Last Wilson
4. DATE OF DEATH: Month October — Day 27 — Year 1956
5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-22-1891
9. AGE (In years last birthday): 65 yrs — If UNDER 1 YEAR: Months — Days — If UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or Foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: C. H. Wilson
14. MOTHER'S MAIDEN NAME: Mary Noland
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Isaac Hampton, Guilford Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Indefinite
DUE TO (b): 1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
4 4 0.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension 1 yr — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH?
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day — Year 19
20d. INJURY OCCURRED: White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐

ACTUAL SIGNATURE: Jesse J. C. Bratton M.D. — CHIEF MEDICAL EXAMINER ☐ — DATE SIGNED
EXAMINER'S NAME (Type): E. Allen Bratton — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — 10-27-1956

22a. BURIAL CREMATION REMOVAL (Specify): Burial
22b. DATE THEREOF: 10/31/56
22c. NAME OF CEMETERY OR CREMATORY: St. Rose
22d. LOCATION (City, town, or county) (State): Cloppers, Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Saunders — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE: Oct 31-56
24b. REGISTRAR'S SIGNATURE: Linda G. Clark

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in the space provided. Do not write the word pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal

VS. A1SME(5) SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10522

10531

CERTIFICATE OF DEATH

Reg. Dist. No. 2-14

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, (Rural)

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring (Rural)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route #2

d. STREET ADDRESS: Route #2

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SARAH — Middle: J — Last: WATKINS

4. DATE OF DEATH: Month: October — Day: 10 — Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 26, 1869

9. AGE (In years last birthday): 87 yrs

IF UNDER 1 YEAR: Months: 7 — Days: 14 — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George A. Broadhurst

14. MOTHER'S MAIDEN NAME: Eliza Snowden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: No

17. INFORMANT: Mrs. Flossie Dodson, Daughter — Address: Rt. #2 Silver Sp. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 19 55 to Oct 10 19 56, that I last saw the deceased alive on Oct 10 19 56, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. F. Thibodeau M.D. — ADDRESS (Street, city or town, state): 10111 Colesville Rd. Silver Spring — DATE SIGNED

PHYSICIAN'S NAME (Type): A. F. Thibodeau, M.D. — 10111 Colesville Rd. S.S. Md — 10/12/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-13-1956

22c. NAME OF CEMETERY OR CREMATORY: Browningsville

22d. LOCATION (City, town, or county) (State): Montgomery, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md

24a. REC'D BY REGISTRAR DATE: 10-22-56

24b. REGISTRAR'S SIGNATURE: Frances Fuller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician and completed by the attending physician as soon as the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10523

Reg. Dist. No 216

1 PLACE OF DEATH a. COUNTY Montgomery *10535 — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia b. COUNTY Randolph

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda

c. LENGTH OF STAY IN 1b: 8 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkins

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS General Delivery

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Anna — Middle Ruby — Last Weese

4 DATE OF DEATH: Month October — Day 5, — Year 19 56

5. SEX: Female

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 29, 1908

9 AGE (In years last birthday): 48 yrs

IF UNDER 1 YEAR: Months 3 — Days 6 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Kitchen helper

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): West Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sterling Van Pelt

14. MOTHER'S MAIDEN NAME: Gertie Hogan

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Not available

17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute Lymphocytic Leukemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Escheria Coli Septicemia

DUE TO (c): Hemorrhage base of brain

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 27th, 19 56 to October 5th, 19 56 that I last saw the deceased alive on October 5th, 19 56, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard R. Engel M.D.

PHYSICIAN'S NAME (Type): Howard R. Engel, M. D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 10/5/56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-trans

22b. DATE THEREOF: 10/5/1956

22c. NAME OF CEMETERY OR CREMATORY: Oddfellows

22d LOCATION (City, town, or county) (State): Elkins, West Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey-7557Wis. Ave. Bethesda, Md

24g. REC'D BY REGISTRAR DATE: 10-6-56

24h. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10536

CERTIFICATE OF DEATH

Reg. Dist. No. 10524 216

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5614 32nd St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lottie — Middle: L. — Last: WEINER

4. DATE OF DEATH: Month: October — Day: 11 — Year: 1956

5 SEX: Female

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 1/30/1870

9 AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): XXXXXXXXXX H. W.

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11 BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17 INFORMANT: Friend-Mr Peterson
Address: 5424 31st Place N.W. Washington 15, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Heart Block with Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Stokes-Adams Syndrome — One week
DUE TO (c): Arteriosclerosis — 5 yrs +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm factory street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from ____ 19 51 to Oct 11 19 56 that I last saw the deceased alive on Oct 11 19 56, and that death occurred at 4:10 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Stewart Clapp M.D. — ADDRESS (Street, city or town, state): 3921 Ingoman St. N.W. — DATE SIGNED: 10/11/56

PHYSICIAN'S NAME (Type): Stewart Clapp — Wash 15 D.C.

22a BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 10-15-56

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d. LOCATION (City, town, or county) (State): Prince George Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A Dunphey — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 10-15-56

24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10537 10525

Reg. Dist No. 211

1. PLACE OF DEATH a. COUNTY: Montgomery, MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montg.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): nr. Comas / c. LENGTH OF STAY IN 1b:	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boyds. Rural
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Slidel Rd.	d. STREET ADDRESS: / e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Leonard Lee White
4. DATE OF DEATH Month Day Year: Oct 26 1956

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/23/1936
9. AGE (In years last birthday): 20 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: Tree Trimmer
11. BIRTHPLACE (State or foreign country): ~~Maryland~~ W.Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter C. White
14. MOTHER'S MAIDEN NAME: Effie Thore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Father - Boyds Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: sudden death

823X

DUE TO (b): Fracture of skull

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Was driver of car that left highway and ran into tree

20c. TIME OF INJURY Hour: 5:15 P.m. Month, Day Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): highway
20f. (City or town): nr. Comas (County): Montg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank J. Broschart
DATE SIGNED: 10/26/56

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 10-29-56
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak
22d. LOCATION (City, town, or county): Gaithersburg (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Pumphrey ADDRESS: Gaithersburg Md.
24a. REC'D BY REGISTRAR DATE: Oct 30 56
24b. REGISTRAR'S SIGNATURE: Della V. Burdette

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A1(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10538

CERTIFICATE OF DEATH

10526

Reg. Dist. No. 217

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c LENGTH OF STAY IN 1b: 6 hrs.
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hospital, Inc

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE: Maryland
b COUNTY: Montgomery
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Josephine Middle Frances Last Williams

4 DATE OF DEATH: Month October Day 24 Year 19 56

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 5/5/62
9 AGE (In years last birthday): 94
IF UNDER 1 YEAR Months 5 Days 19 IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Virginia
12 CITIZEN OF WHAT COUNTRY: USA

13 FATHER'S NAME: Jacob Lambert
14 MOTHER'S MAIDEN NAME: Becky Shull

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO:
17 INFORMANT Address: Hospital Record (Granddaughter)

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): LOBAR PNEUMONIA - R LL. — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from October 23, 19 56, to October 24, 19 56, that I last saw the deceased alive on October 23, 19 56, and that death occurred at 1:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: G. H. Ligon M.D.
ADDRESS (Street, city or town, state): Sandy Spring, Maryland
DATE SIGNED:

PHYSICIAN'S NAME (Type): G. H. Ligon, M. D.
Sandy Spring, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 10-26-56
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d LOCATION (City, town, or county) (State): Montgomery Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Humphrey
ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 10-25-56
24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10527

10539

CERTIFICATE OF DEATH

Reg Dist. No. 215

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN 1b: 2 months

d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. STREET ADDRESS: 1869 Wyoming Ave., N.W.

e. RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Margaret — Middle: Pinkney — Last: WILLIAMS

4 DATE OF DEATH: Month: Oct. — Day: 3 — Year: 19 56

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8 DATE OF BIRTH: 29 March 1894

9 AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS: Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John r. Frantz

14 MOTHER'S MAIDEN NAME: (First name unknown) DeNNEAD

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: Unknown

17 INFORMANT — Address: (Husband) Raleigh C. Williams (Same As #2)

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b). and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 162 X

DUE TO

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c) Carcinoma of lung with metastases

INTERVAL BETWEEN ONSET AND DEATH: 9 mos.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3 Aug. 19 56 to 3 Oct. 19 56 that I last saw the deceased alive on 3 Oct. 19 56, and that death occurred at 1:50 P. M. from the causes and on the date stated above

ACTUAL SIGNATURE: Russell Miller Jr. M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 10-3-56

PHYSICIAN'S NAME (Type): Russell Miller, Jr., MD U.S. Naval Hospital, Bethesda, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8 Oct. 1956

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

22d. LOCATION (City, town or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: 4th & Mass Ave. N.E. Washington D.C.

24a. REC'D BY REGISTRAR DATE: 10-3-56

24b. REGISTRAR'S SIGNATURE: Mary E. Farrell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be removed by the hospital or attending physician or TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A35 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10540

CERTIFICATE OF DEATH

10525

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): Bethesda 14, Maryland

c. LENGTH OF STAY IN 1b: 17 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 1252 Oates Street, N.E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Booker — Middle: Taliaferro — Last: Williamson

4 DATE OF DEATH: Month: October — Day: 25, — Year: 1956

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: May 30, 1911

9 AGE (In years last birthday): 45 yrs

IF UNDER 1 YEAR OR UNDER 24 HRS: Months | Days | Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Library Assistant

10b. KIND OF BUSINESS OR INDUSTRY: US Government

11 BIRTHPLACE (State or foreign country): Florida

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William E. Williamson

14. MOTHER'S MAIDEN NAME: Hattie Adams

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — If yes, give war or dates of service:

16. SOCIAL SECURITY NO: 578-20-4749

17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): PNEUMONIA, LUNGS BILATERAL — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CHRONIC MYELOGENOUS LEUKEMIA

DUE TO

(c) HEMORRHAGE, LUNGS, BILATERAL

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT? WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. / p. m. 19

20d INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from October 8, 1956, to October 25, 1956, that I last saw the deceased alive on October 25, 1956, and that death occurred at 7:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. W. Weiger M.D. — R. W. Weiger, M.D.

PHYSICIAN'S NAME (Type): R. W. WEIGER, M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 10-25-56

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10/30/56

22c. NAME OF CEMETERY OR CREMATORY: Lincoln

22d LOCATION (City, town, or county) (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest Davis — ADDRESS: 1432 Upshur St NW

24a. REC'D BY REGISTRAR DATE: 10 29 1956

24b. REGISTRAR'S SIGNATURE: Jessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10541

CERTIFICATE OF DEATH

10529

Reg. Dist. No. 216

1 PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Maryland — b. COUNTY: Prince George

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Md.

c. LENGTH OF STAY IN 1b: 103 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 3322 Chauncy Place

e. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Martha — Middle: Lee — Last: Wilson

4. DATE OF DEATH: Month: October — Day: 9, — Year: 19 56

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 26, 1909

9. AGE (In years last birthday): 46 yrs — IF UNDER 1 YEAR: Months: 10 — Days: 13 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress

10b. KIND OF BUSINESS OR INDUSTRY: Waitress Work

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Bunion Faulkner

14. MOTHER'S MAIDEN NAME: Eula Lynch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 245-03-6756

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): [illegible]

DUE TO (b): [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY: Home, farm, factory, street, office bldg., etc.

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 29, 1956, to October 9, 1956, that I last saw the deceased alive on October 9, 1956, and that death occurred at 2:45 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Chester Z Haverback M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 10/9/56

PHYSICIAN'S NAME (Type): Chester Z. Haverback, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Pr.

22b. DATE THEREOF: 10-10-56

22c. NAME OF CEMETERY OR CREMATORY: Elmwood

22d. LOCATION (City, town, or county) (State): Oxford, N.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda Md

24a. REC'D BY REGISTRAR DATE: 10-11-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician or by the funeral director may be retained by the DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10542

10590

CERTIFICATE OF DEATH

Reg. Dist No. 24

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: Suburban Hosp.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 8205 New Hampshire Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Harry — Middle: Lewis — Last: Wolfson

4 DATE OF DEATH: Month: Oct. — Day: 24 — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 16, 1891

9 AGE (In years last birthday): 65 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clothing Store Owner

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Russia

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mordecai Wolfson

14. MOTHER'S MAIDEN NAME: Margola —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT Address: Ida Wolfson - wife above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from June 1956 to Oct 24 1956, that I last saw the deceased alive on Oct 24 1956, and that death occurred at 2:30 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul D. Canton M.D. ADDRESS (Street, city or town, state): 4709 Montgomery Lane - suite 4 - 2nd DATE SIGNED: 10/27/56

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 10/29/56

22c. NAME OF CEMETERY OR CREMATORY: Nat. Cap. Hebrew Cem.

22d. LOCATION (City, town or county) (State): Wash. D.C.

23 FUNERAL DIRECTOR'S SIGNATURE: B. DANZANSKY & SONS ADDRESS: Wash. D.C.

24a REC'D BY REGISTRAR DATE: 10/30/56

24b. REGISTRAR'S SIGNATURE: Frances Cotter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial cremation or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10531

10425

CERTIFICATE OF DEATH

Reg Dist. No. 223

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
LENGTH OF STAY IN 1b 4 days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington.
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Washington San. & Hospital
d. STREET ADDRESS 5919 - 13th St NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE DC
b. COUNTY

3 NAME OF DECEASED (Type or print) First May Middle Balbenia Last Wood

4 DATE OF DEATH Month 10 Day 10 Year 1956

5 SEX fe.
6. COLOR OR RACE White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3-31-76
9 AGE (In years last birthday) 80 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Household duties
10b KIND OF BUSINESS OR INDUSTRY Own home
11 BIRTHPLACE (State or foreign country) D C.
12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Austin Lysight
14 MOTHER'S MAIDEN NAME — McTEE

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) None!
16. SOCIAL SECURITY NO. NONE
17 INFORMANT Address Daughter & Wash. San & Hosp Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Respiratory Failure	5 minutes
2X DUE TO (b)	Cerebral Thrombosis	3 days
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c)	Cerebral Arteriosclerosis	YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerotic Heart Disease

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 7 1956 to Oct 11 1956, that I last saw the deceased alive on October 9 1956, and that death occurred at 7:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Jack Cowell M.D. ADDRESS (Street, city or town, state) 2025 Eye St. N.W. Wash, DC DATE SIGNED 10/12/56

PHYSICIAN'S NAME (Type) Jack Cowell III

22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b DATE THEREOF 10/12/56
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY
22d LOCATION (City, town, or county) (State) FREDERICK, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James E. Tomblyn 8434 Fenton Ave Silver Spring Md
24a. REC'D BY REGISTRAR DATE 10/13/56
24b REGISTRAR'S SIGNATURE J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10532

10543

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C. b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland

c. LENGTH OF STAY IN 1b: 72 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 1346 Pennsylvania Ave., S. E.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arlie — Middle: (none) — Last: Woodring

4. DATE OF DEATH: Month: October — Day: 24, — Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 29, 1894

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Inspector

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Government

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Zenas W. Woodring

14. MOTHER'S MAIDEN NAME: Ella Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 579-01-0008

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Malignant melanoma metastatic to Brain Lung etc. — 4 years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 13, 1956 to October 24 1956 that I last saw the deceased alive on October 24, 1956, and that death occurred at 7:30 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas Waldmann M.D. — ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland — DATE SIGNED: 10/25/56

PHYSICIAN'S NAME (Type): Thomas Waldmann, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 10-29-56

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.

22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W. A. Chambers — ADDRESS: 517-11th St. S.E.

24a. REC'D BY REGISTRAR DATE: 10-29-56

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10426

CERTIFICATE OF DEATH

10533

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ———
b. COUNTY: ———

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park

c. LENGTH OF STAY IN 1b: 5 days 10hrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Of Columbia 47x

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

d. STREET ADDRESS: 6202 7th St. N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Francis Last: Wright

4. DATE OF DEATH: Month: Oct. Day: 24 Year: 1956

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-I-02

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months: ——— Days: ———
IF UNDER 24 HRS.: Hours: ——— Min.: ———

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Bldg. Supt.

11. BIRTHPLACE (State or foreign country): D. C.

12. CITIZEN OF WHAT COUNTRY?: Amer.

13. FATHER'S NAME: Edward Wright

14. MOTHER'S MAIDEN NAME: Margaret Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WWI Navy

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchogenic Ca of L Lung — INTERVAL BETWEEN ONSET AND DEATH: 10 Mos T. Y.

162x

DUE TO (b): Hypertension & Arteriosclerosis — 3–4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: ——— a. m. p. m. Month: ——— Day: ——— Year: 19——

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ~~Last Beg. 19——~~ to 10/24/ 1956, that I last saw the deceased alive on 10/23/ 1956, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Chas H Wilcox M.D.

ADDRESS (Street, city or town, state): 5001 Underwood St. N.W. 10

DATE SIGNED

PHYSICIAN'S NAME (Type): Chas H WILCOX Washington, DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Oct. 29, 1956

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat.

22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home

ADDRESS: Wash. D. C. 4812 Ga. Ave.

24a. REC'D BY REGISTRAR DATE: 10/29/1956

24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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